| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155493 | A. BUILDING 00<br>B. WING | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SCENIC HILLS AT THE MONASTERY | 710 SUNRISE DRIVE<br>FERDINAND, IN 47532 |

| (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 |
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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: March 4, 5, 6, 7, 10, 2025<br><br>Facility number: 000534<br>Provider number: 155493<br>AIM number: 100267220<br><br>Census Bed Type:<br>SNF/NF: 68<br>SNF: 20<br>Residential: 34<br>Total: 122<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 45<br>Other: 33<br>Total: 88<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on March 17, 2025. | F 0000 | The submission of this plan of correction does not indicate an admission by Scenic Hills at the Monastery that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Scenic Hills at the Monastery. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br><br>Based on observation, interview, and record review, the facility failed to maintain resident dignity, and to protect and promote the rights of the residents. A dependent resident waited several minutes to be assisted to eat during 2 of 2 meals observed. (Resident 42) | F 0550 | 1 Resident 42 was assessed and no adverse effects noted from alleged deficient practice.<br>2 All residents have the potential to be affected. Education provided to nursing personnel on resident rights; ensuring residents | 04/04/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Bailey Sherman | Executive Director | 03/27/2025 |

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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| | Findings include:<br><br>During a continuous observation on 3/4/25 from 11:30 A.M. through 12:00 P.M., the following was observed on the locked unit:<br>11:33 A.M. A lunch cart was brought to the unit.<br><br>11:41 A.M. A lunch plate was placed in front of Resident 42, who was sitting in a high back chair at the table.<br><br>11:54 A.M. Legacy Leader 3 was observed serving cake to several residents.<br><br>11:58 P.M. The two other residents at the table with Resident 42 finished their meals.<br><br>12:00 P.M. Certified Nurse Aide (CNA) 5 sat with Resident 42 to begin assisting to eat the meal (19 minutes after it had been placed in front of the resident).<br><br>On 3/5/25 at 12:24 P.M., Resident 42's clinical record was reviewed. Diagnoses included, but was not limited to, hemiplegia/hemiparesis following stroke.<br><br>The most recent Annual Minimum Data Set (MDS) assessment, dated 1/29/25, indicated a severe cognitive impairment and supervision or touching assistance required for eating.<br><br>Activities of Daily Living (ADL) review for March 2025 indicated Resident 42 required staff assistance with meals.<br><br>A current impairment in functioning status care plan, last revised 2/4/25, indicated resident required assistance with eating. | | that require assistance with meals receive assistance when meal is served.<br>3 As a measure of ongoing compliance, the DHS or designee will audit to ensure residents that require assistance with meals receive assistance when meal is served. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | |

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| | A current risk for malnourishment care plan, last revised 2/4/25, indicated to assist with meals as needed.<br><br>A current significant weight loss care plan, last revised 2/4/25, indicated to offer encouragement and assistance with eating as needed.<br><br>During a continuous observation on 3/6/25 from 11:27 A.M. through 12:07 P.M., the following was observed on the locked unit:<br>11:27 A.M. Drinks were served to the residents. Resident 42 was observed sitting at a table with three other residents.<br><br>11:47 A.M. Staff began serving plates to the residents at Resident 42's table.<br><br>11:49 A.M. A meal plate was placed in front of Resident 42. At that time, Resident 42 looked at the plate, and reached for the cutlery on the table but was unable to reach it. Resident 42 placed his hand back in his lap and shut his eyes.<br><br>11:56 A.M. Legacy Leader 3 was observed walking around the dining room, cleaning up while other residents were eating. CNA 5 walked down the hall and into a resident's room.<br><br>11:59 A.M. CNA 5 indicated to Licensed Practical Nurse (LPN) 9 that she was going to the kitchen. LPN 9 entered the dining room area and began speaking with another resident.<br><br>12:05 P.M. CNA 5 asked the residents in the dining room if they were doing okay and if anyone needed more to drink. CNA 5 then refilled drinks as requested.<br><br>12:07 P.M. CNA 5 sat with Resident 42 to begin | | | |

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| | assisting to eat the meal (18 minutes after it had been placed in front of the resident).<br><br>On 3/6/25 at 1:55 P.M., LPN 9 indicated Resident 42 usually required staff assistance with meals. She indicated the resident would sometimes eat finger foods independently, but still required a lot of encouragement and supervision to do so.<br><br>On 3/7/25 at 9:44 A.M., CNA 7 indicated staff would serve all residents then assist those that required assistance. CNA 7 was unaware of any protocol for not placing food in front of residents and waiting to assist them to eat.<br><br>On 3/7/25 at 2:13 P.M., the Administrator provided a current Resident Rights policy, dated 12/17/24, that indicated "To ensure resident rights are respected and protected and provide an environment in which they can be exercised ... Our residents have a right to ... Be treated with dignity and respect"<br><br>3.1-3(t)<br>3.1-3(v)(1) | | | |
| F 0658<br>SS=D<br>Bldg. 00 | 483.21(b)(3)(i)<br>Services Provided Meet Professional Standards<br>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for 1 of 1 residents reviewed for skin conditions. A blister on a resident was not assessed when initially identified, the nurse was unaware of the correct timing of the treatment, and the area was not cleaned appropriately. (Resident 40)<br><br>Findings include: | F 0658 | 1 Resident 40 was assessed, and no adverse effects noted by alleged deficient practice.<br>2 All residents with a skin impairment have the potential to be affected. During CCM (clinical care meeting) review of residents in house for any new skin impairments and ensure documentation of measurements and treatment are present. | 04/04/2025 |

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| | On 3/5/25 at 1:04 P.M., Resident 40's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's, malnutrition, and depression.<br><br>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated a severe cognitive impairment. Resident 40 required substantial to maximum assistance (helper does more than half the effort) with toileting, showers, med mobility, and transfers.<br><br>Current physician orders included the following: Inner left thigh: fluid filled blister. cover with border gauze, change daily and monitor until healed, dated 2/23/25.<br><br>Blister on left upper thigh: cleanse wound with wound cleanser or normal saline, apply skin prep to peri-wound, and cover with foam dressing, change every 5 days, dated 2/28/25.<br><br>Resident 40's clinical record lacked a care plan specific to the blister on the left thigh.<br><br>A progress note, dated 2/23/25, indicated a fluid filled blister on the left inner thigh was identified. The note lacked an assessment or measurement of the area.<br><br>A progress note, dated 2/28/25, indicated a new blister had been identified on the left upper thigh measuring 2.5 cm (centimeters) x 2.7 cm x 0 cm. The blister was open and draining with partial skin flap loss.<br><br>A Wound Management Detail Report, dated 2/28/25, indicated a blister on the left thigh had been identified 2/28/25 and measured 2.5 cm x 2.7 cm. At that time, there was only one assessment | | Nursing personnel educated on dressing change and documentation of skin impairment policy and procedures.<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident records of residents with skin impairments to review to ensure measurements are placed at time of identification. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>As a measure of ongoing compliance, the DHS or designee will complete random audits of wound care being complete on residents with noted skin impairment to ensure proper technique being completed . Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | |

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| | of the wound.<br><br>On 3/6/25 at 1:27 P.M., Licensed Practical Nurse (LPN) 9 indicated she had spoken with Resident 40's hospice nurse who indicated they had not changed the dressing to the left thigh the previous day because they thought it was supposed to be changed every other day. LPN 9 was then observed to gather supplies and assist Resident 40 into her bathroom to change the dressing. LPN 9 put on gloves and assisted the resident to pull her pants and brief down. Without changing gloves, she removed the old dressing (dated 3/5 and with LPN 9's initials), sprayed wound cleanser on gauze, and wiped the entire area of the wound going from inside the would outwards, as well as outside the wound area to inside the wound. LPN 9 then repeated the process with a second gauze. At that time, an open area was observed on Resident 40's thigh that was pink in the middle. The resident then indicated to the LPN that the area where the adhesive was had irritated the skin. That area was observed to be pink and irritated with several red dots throughout. LPN 9 indicated to the resident she had not seen the irritated area due to her glasses not being on at the time, and would not have noticed if the resident had not pointed it out. LPN 9 then changed her gloves and put a clean bandage on the area, not covering the area of skin where the adhesive was prior. Skin prep was not applied to the area around the wound.<br><br>On 3/6/25 at 2:16 P.M., LPN 9 documented a progress note that indicated small blisters had been noted in the area of the adhesive from the prior bandage. The original area was cleaned and a new dressing applied, but new blisters not covered. The hospice nurse was contacted about the new areas and indicated she would come to | | | |

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| | the facility to assess, measure, and look into a new dressing for the area.<br><br>On 3/6/25, a new physician's order was placed for the blister on the left upper thigh to cleanse wound with wound cleanser and apply foam border dressing, change every 3 days.<br><br>The irritated area under the adhesive was not addressed in the physician orders, care plans, wound management, or progress notes.<br><br>On 3/7/25 at 11:15 A.M., the Regional Consultant indicated typically the nurse that identified a new skin area would assess the area and document measurements. She indicated she did not know why Resident 40's area on the left thigh was not assessed or measured on 2/23/25. She further indicated all nurses received yearly inservices for wound care and dressings.<br><br>On 3/7/25 at 2:13 P.M., the Administrator provided a current Dressing Changes policy, dated 12/16/24, that indicated "To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination" The policy indicated to change gloves after removing a soiled dressing prior to cleaning the would or applying a new treatment.<br><br>On 3/7/25 at 2:13 P.M., the Administrator provided a current undated LPN job description that indicated "The Licensed Practical Nurse (LPN) is primarily responsible to provide quality care, appropriate to the ages and needs of the residents/patients served"<br><br>3.1-35(g)(1) | | | |

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| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistance devices were received to prevent accidents for 1 of 4 residents reviewed for falls. A resident's mattress was not moved with the resident during a room change resulting in a fall, and fall interventions were observed not in place. (Resident 40)<br><br>Findings include:<br><br>On 3/5/25 at 1:04 P.M., Resident 40's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's, malnutrition, and depression.<br><br>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated a severe cognitive impairment, no behaviors, and no falls. Resident required substantial to maximum assistance (helper does more than half the effort) with toileting, showers, bed mobility, and transfers.<br><br>Current physician orders included, but were not limited to:<br>Dycem to wheelchair. Monitor placement every shift with foot pedals in place, dated 2/26/24.<br><br>Pressure reducing parameter mattress with bed in lowest position, dated 8/21/23.<br><br>A current falls care plan, last revised 2/20/25, included, but was not limited to, the following interventions:<br>Parameter mattress with bed in lowest position, dated 8/7/23. | F 0689 | 1 Resident 40 was assessed, and no adverse effects noted related to the alleged deficient practice.<br>2 All residents have the potential to be affected by the alleged deficiency. Audit completed of current residents fall interventions to ensure interventions are in place. Education completed with nursing personnel regarding resident fall interventions and ensuring items in place.<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident rooms to ensure appropriate/ordered fall interventions are in place. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS/designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | 04/04/2025 |

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| | Mattress replaced, dated 2/17/25.<br><br>Stop sign on room door to prevent other residents from entering room, dated 9/24/24.<br><br>Dycem to wheelchair with foot pedals in place, dated 2/26/24.<br><br>"Call don't fall" sign to room (on room and walker), visible from bed and chair, dated 3/13/23.<br><br>Bed against wall and in lowest position, dated 9/24/24.<br><br>Mat to exit side of bed, dated 10/7/24.<br><br>From September 2024 through March 2025, Resident 40 experienced the following falls:<br>Fall 1<br>9/19/24 While the resident was in the bathroom with a Certified Nurse Aide (CNA), another resident attempted to open the door causing Resident 40 to lose balance. The CNA lowered Resident 40 to the floor but did hit head on the door frame. A new intervention for a stop sign on the room door was placed and care plan updated on 9/24/24.<br><br>Fall 2<br>9/24/24 Resident rolled out of bed. A new intervention for the bed to be against the wall was placed and care plan updated 9/24/24.<br><br>Fall 3<br>10/6/24 Resident rolled out of bed. Resident indicated she was "moving in bed and slipped out". A new intervention for a fall mat to be placed in the floor on open side of the bed was placed and care plan updated 10/7/24. | | | |

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| | Fall 4<br>2/17/25 Resident was found on the floor after observed in bed. An Interdisciplinary Team (IDT) note, dated 2/17/25, indicated resident was attempting to roll over in bed and unable to determine edges causing the fall. The note indicated Resident 40 had recently changed rooms and previous perimeter mattress had not been placed on the new bed. An intervention to replace the perimeter mattress was placed and the care plan updated 2/17/25.<br><br>A current CNA assignment sheet, dated 2/26/25, indicated Resident 40 had a "call don't fall" sign on wall, Dycem to wheelchair with foot pedals in place, and a stop sign on room door to prevent other residents from entering.<br><br>On 3/6/25 at 1:27 P.M., while observing Licensed Practical Nurse (LPN) 9 do a dressing change, Resident 40 was observed with no Dycem to the wheelchair, and no foot pedals. A "call don't fall" sign was observed on the same wall as the head of the bed, not visible if the resident were lying in the bed. A stop sign was not observed on the room door.<br><br>On 3/6/25 at 2:51 P.M., Resident 40 was observed sitting in the dining room doing a puzzle. No foot pedals were observed on the wheelchair.<br><br>On 3/7/25 at 7:08 A.M., Resident 40 was observed sitting in the dining room. No foot pedals were observed on the wheelchair. At that time, Qualified Medication Aide (QMA) 13 indicated Resident 40 used to have a stop sign on her old door, but did not know why the sign was no longer there or why the resident would need one. She further indicated she was unaware if Resident | | | |

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| | 40 had an order for foot pedals, and didn't think she needed them.<br><br>On 3/7/25 at 2:17 P.M., the Regional Consultant indicated although there was no written policy for following care plans, it was the facility's policy to follow care plan interventions as written.<br><br>On 3/7/25 at 2:13 P.M., the Administrator provided a current Fall Management policy, dated 12/17/24, that indicated "(Company) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures ... Care plan interventions should be implemented that address the resident's risk factors ... Any orders received from the physician should be noted and carried out"<br><br>3.1-45(a) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of diseases and infections for 1 of 1 residents reviewed for skin conditions, and the facility failed to properly prevent and/or contain COVID-19 for 2 random observation. Staff failed to use proper Personal Protective Equipment (PPE) when providing care of residents and entering a COVID-19 room, did not clean a wound or wash hands with appropriate infection control techniques, did not change gloves between tasks, and touched medication with bare hands prior to administering to a resident. (Resident 40, Resident 52, Resident 81) | F 0880 | 1 Residents 40, 52, and 81 were not affected by the alleged deficient practice. No adverse effects noted to Residents 40, 52, and 81.<br>2 All residents have the potential to be affected. Education provided to facility staff on Infection control practices, including hand hygiene, glove usage, medication administration, and Transmission based precautions (TBP).<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audits of hand hygiene and resident care to | 04/04/2025 |

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| | 155493 | A. BUILDING 00<br>B. WING | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SCENIC HILLS AT THE MONASTERY | 710 SUNRISE DRIVE<br>FERDINAND, IN 47532 |

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| | Findings include:<br><br>1. On 3/5/25 at 1:04 P.M., Resident 40's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's, malnutrition, and depression.<br><br>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated a severe cognitive impairment. Resident 40 required substantial to maximum assistance (helper does more than half the effort) with toileting, showers, med mobility, and transfers.<br><br>Current physician orders included, but were not limited to, the following:<br>Staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities, dated 1/30/25.<br><br>On 3/6/25 at 1:27 P.M., Licensed Practical Nurse (LPN) 9 was observed to change Resident 40's dressing on her left thigh. LPN 9 brought the resident into her bathroom, put on gloves and assisted the resident to pull her pants and brief down. Without changing gloves, she removed the old dressing, sprayed wound cleanser on gauze, and wiped the entire area of the wound going from inside the would outwards, as well as outside the wound area to inside the wound. LPN 9 then repeated the process with a second gauze. LPN 9 then changed her gloves, put a clean dressing on the area, then removed the resident's soiled brief. A clean brief was obtained without changing gloves. LPN 9 placed the clean brief under Resident 40's foot, then slid the brief through the pant leg onto the other foot. When sliding the brief over the second foot, the inside of the brief touched the bottom of the resident's shoe. LPN 9 assisted the resident to stand, wiped | | ensure appropriate hand hygiene is being utilized. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>As a measure of ongoing compliance, the DHS or designee will complete random audits of resident care to ensure appropriate glove usage or TBP if applicable is being utilized. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>As a measure of ongoing compliance, the DHS or designee will complete random audits of resident medication administration to ensure appropriate infection control practices are being utilized. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | |

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| | the resident's peri area, then pulled the brief and pants up still without changing gloves. The resident was assisted to sit in the wheelchair, then LPN 9 removed her gloves and washed hands with a three second lather with soap.<br><br>On 3/7/25 at 10:59 A.M., Qualified Nurse Aide (QMA) 7 was observed assisting Resident 40 with toileting. QMA 7 assisted the resident into her bathroom and put on a pair of gloves, but did not put on a gown. Without changing gloves, QMA 7 removed the soiled brief, cleaned the resident, and put on a clean brief. QMA 7 placed a clean brief under Resident 40's foot, then slid the brief through the pant leg onto the other foot. When sliding the brief over the second foot, the inside of the brief touched the bottom of the resident's shoe. After assisting the resident back to the wheelchair, QMA 7 did not offer the resident to wash her hands at the sink, and wheeled her out of the room.<br><br>2. On 3/7/25 at 7:38 A.M., LPN 9 was observed to prepare medications for Resident 52. While placing medications into a medication cup, a pill was dropped onto the medication cart. LPN 9 picked up the pill with a bare hand, and placed it into the medication cup with the other medication. The medication was then administered to the resident.<br><br>On 3/7/25 at 10:37 A.M., the Regional Consultant indicated nurses were given yearly inservices and training with wound care and dressings.<br><br>On 3/10/25 at 8:51 A.M., the Infection Preventionist (IP) indicated if a pill fell on a medication cart, staff should destroy the pill and obtain a new one. Staff should not handle pills with bare hands. She further indicated hand | | | |

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| | washing should be performed with at least a 20 second lather, and gloves should be changed between dirty and clean tasks. The IP indicated if a clean brief scraped the bottom of a resident's shoe, staff should have discarded the brief and obtained a clean one. She also indicated staff should wear a gown and gloves when providing incontinence care or toileting for a resident on enhanced barrier precautions, and should offer for the resident to wash their hands after toileting.<br><br>3. On 3/7/25 at 10:39 A.M., Certified Nurse Aide (CNA) 22 was observed going into Resident 81's room to answer the call light. Resident 81 was on droplet precautions at that time. Before she entered, CNA 22 put on a gown and gloves, placed an N95 mask (special mask that filters out airborne particles such as viruses) over the surgical mask she was wearing, and put on a face shield.<br><br>On 3/7/25 at 10:43 A.M., CNA 22 came out of Resident 81's room wearing a surgical mask and didn't change it. She used antibacterial hand rub, adjusted the mask, and carried a trash bag into the soiled linen room. Then CNA 22 went into the drink station, across from the nurse's station, and washed her hands using a three second lather.<br><br>On 3/7/25 at 10:57 A.M., Resident 81's clinical record was reviewed. Diagnoses included, but were not limited to, cough, nasal drainage, and sore throat.<br><br>Current Physician's Orders included, but were not limited to the following:<br>Quarantine-Resident to stay in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room, ordered 3/6/25 | | | |

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| | Contact/Droplet Precautions, ordered 3/6/25<br><br>An Isolation Care Plan, dated 3/6/25, indicated the resident had need for isolation related to active signs and symptoms of infectious disease related to COVID-19.<br><br>During an interview on 3/10/25 at 8:51 A.M., the Regional Consultant indicated staff were to use droplet precautions when entering the room of a resident with symptoms of COVID-19. Proper PPE for droplet precautions included a gown, gloves, face shield or goggles, and an N95 mask. The N95 mask should not be placed over their surgical mask.<br><br>On 3/7/25 at 2:13 P.M., a current Droplet Precautions Policy, last reviewed 12/17/24, was provided by the Executive Director and indicated " ... Droplet precautions should be used for an individual with documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing ... examples of infections requiring Droplet Precautions include ... 7. confirmed/suspected COVID-19 ...<br><br>On 3/7/25 at 2:13 P.M., a current Handwashing/Hand Hygiene policy, dated 12/17/24, was provided and indicated "Residents shall be given the opportunity and assistance to wash their hands ... after toileting ... Wash well for at least 20 seconds, using a rotary motion and friction"<br><br>On 3/7/25 at 2:13 P.M., a current Medication Administration policy, dated 11/18, was provided and indicated "Medications are administered as prescribed in accordance with good nursing principles" | | | |

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| | On 3/10/25 at 10:00 A.M., the Regional Consultant provided a current Enhanced Barrier Precautions policy, dated 4/1/24, that indicated "Personal Protective Equipment (PPE) should be used even if blood and body fluid exposure is not anticipated ... At minimum, staff shall wear gloves and gowns during high-contact activities"<br><br>On 3/10/25 at 10:00 A.M., the Regional Consultant provided a current Perineal Care for Incontinence policy, dated 12/16/24, that indicated "Pay particular attention to infection prevention and control techniques when performing pericare, to prevent introduction of contamination that may lead to a urinary tract infection"<br><br>3.1-18(b)(2)<br>3.1-18(l) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.<br><br>Survey dates: March 4, 5, 6, 7, 10, 2025<br><br>Facility number: 000534<br><br>Residential Census: 34<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5. | R 0000 | The submission of this plan of correction does not indicate an admission by Scenic Hills at the Monastery that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Scenic Hills at the Monastery. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and | |

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| | | | federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. | |
| R 0407<br><br>Bldg. 00 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance<br><br>Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 for 1 of 1 random observations of staff donning Personal Protective Equipment (PPE). Staff failed to use proper Personal Protective Equipment (PPE) when entering a COVID 19 room . (Resident 106)<br><br>Findings include:<br><br>On 3/7/25 at 9:39 A.M., Certified Nurse Aide (CNA) 14 was observed putting on PPE prior to entering Resident 106's room to pass water and ask the resident about taking a shower. There was a sign on the door to use droplet precautions. CNA 14 put on a gown, gloves, and a face shield over the surgical mask she was wearing. She did not wear an N95 mask into the room.<br><br>On 3/7/25 at 11:20 A.M., Resident 106's clinical record was reviewed. Diagnoses included, but were not limited to, COVID-19.<br><br>Current Physician's Orders, included, but were not limited to, the following:<br>Quarantine-Resident to stay in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room, ordered | R 0407 | 1 Residents 106 were not affected by the alleged deficient practice. No adverse effects noted to Residents 106.<br>2 All residents have the potential to be affected. Education provided to facility staff on Infection control practices, including proper personal protective equipment (PPE) use when caring for a resident on Transmission based precautions (TBP).<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident care to ensure proper personal protective equipment (PPE) use when caring for a resident on Transmission based precautions (TBP. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until | 04/04/2025 |

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| | 3/6/25<br>Contact/Droplet Precautions, ordered 3/6/25<br><br>During an interview on 3/10/25 at 8:51 A.M., the Regional Consultant indicated staff were to use droplet precautions when entering the room of a resident with symptoms of COVID-19. Proper PPE for droplet precautions included a gown, gloves, face shield or goggles, and an N95 mask.<br><br>On 3/7/25 at 2:13 P.M., a current Droplet Precautions Policy, last reviewed 12/17/24, was provided by the Executive Director and indicated " ... Droplet precautions should be used for an individual with documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing ... examples of infections requiring Droplet Precautions include ... 7. confirmed/suspected COVID-19 ... | | campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br><br>Based on interview, observation, and record review, the facility failed to ensure tuberculin (TB) skin tests were completed and read for 3 of 7 residents reviewed. Resident's failed to receive the 2nd step TB skin test after admission, and TB skin tests were not read after they were given. (Resident 106, Resident 107, Resident 103)<br><br>Findings include:<br><br>1. On 3/7/25 at 10:46 A.M., Resident 106's clinical record was reviewed. Diagnosis included, but was not limited to, Alzheimer's disease. Resident 106 was admitted to the facility on 2/8/25.<br><br>The facility failed to read the step 1 TB skin test | R 0410 | 1 Residents 106, 107, and 103 were assessed and no adverse effects noted from alleged deficient practice.<br>2 All residents have the potential to be affected. Education provided to nursing personnel on Tuberculin (TB) prevention policy and procedure. Audit completed of residents to ensure all TB skin tests present if applicable.<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audit of resident records to ensure appropriate TB skin testing was | 04/04/2025 |

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| | that was given on 2/8/25.<br><br>The facility failed to read the step 2 TB skin test that was given on 2/24/25.<br><br>2. On 3/7/25 at 1:25 P.M., Resident 107's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. Resident 107 was admitted to the facility on 11/8/24.<br><br>The facility failed to administer the 2nd step TB test for Resident 107.<br><br>During an interview on 3/7/24 at 2:14 P.M., the Regional Consultant indicated the facility failed to read Resident 106's TB tests, and failed to provide the 2nd step for Resident 107. At that time, she indicated she would expect a 1st and 2nd step TB test and would expect the tests to be read.<br>3. On 3/7/25 at 11:51 A.M., Resident 103's clinical record was reviewed. Diagnoses included, but were not limited to pain in left knee, presence of cardiac pacemaker, dizziness and giddiness, generalized anxiety disorder, and personal history of malignant neoplasm of breast. Resident 103 was admitted on 1/24/25.<br><br>The facility failed to read the step 1 TB skin test that was given on 1/25/25.<br><br>During an interview on 3/7/25 at 2:55 P.M., the Executive Director indicated step 1 TB test was given to Resident 103 but not read.<br><br>On 3/10/25 at 9:59 A.M., the Regional Consultant provided a current Tuberculin Testing Guidelines policy, revised 4/17/24 that indicated, "...Second step shall be administered between 1-3 weeks after the first test...Observe the reaction 48 to 72 hours after the test is given..." | | completed and documented. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. | |

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