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	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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 a State Residential Licensure Survey. Survey dates: March 26 and 27, 2024 Facility number: 014706 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 2, 2024.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 05/01/2024.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Combs MBA HFA	Executive Director	04/15/2024

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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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were performed on each shift quarterly resulting in at least twelve (12) drills each year to familiarize all staff of emergency signals and actions. This deficient practice had the potential to negatively affect 90 of 90 residents who resided in the facility. Findings include: During an interview, on 3/26/24 at 1:36 p.m., the Administrator indicated the facility staff work 8-hour shifts and this calculated into 3 shifts per day. A review of the facility fire drills, provided by the Administrator, on 3/26/24 at 10:20 a.m., for January 2023 to February 2024 (a 13-month period) indicated the following: During the period, four (4) first shift fire drills were completed as follows: February 2023, April 2023, July 2023, and November 2023. During the period, six (6) second shift fire drills were completed as follows: March 2023, June 2023, August 2023, September 2023- the fire drill took place on October 3, 2023, October 2023, and December 2023. During the period, two (2) third shift drills were completed as follows: January 2023 and January 2024-the fire drill took place on February 1, 2024 on 3rd shift.	R 0092	It is the intent of Sweet Galilee to conduct fire drills as required by 410 IAC 16.2-5-1.3. This deficiency had the potential to affect all residents. The deficiency was corrected upon identification. The community utilizes TELS for documentation of fire drills. As a preventive measure, maintenance staff will be re-educated by the ED on Fire Drill Policy & Procedure by 05/01/2024. To prevent reoccurrence, the Maintenance Director/Designee will audit fire drills as they occur to ensure compliance. Any findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	05/01/2024

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	During an interview, on 3/27/24 at 10:45 a.m., the Director of Environmental Services, indicated he started this position in June of 2023 and he utilized the "Direct Supply TELS" system to keep track of when fire drills are due, on which shift fire drills are to be performed, and when to contact the local fire departments to request their participation. He indicated he ran the fire drills himself, collected signatures from the employees present, and kept documentation in the TELS system. During a follow-up interview, on 3/27/24 at 12:37 a.m., the Director of Environmental Services indicated he was made aware the fire drill from May 2023 was missing when he hired. He tried to follow the recommendations for the timing of drills, provided by the "TELS" system, but at times he was not able to complete the drills on 3rd shift. No facility policy was provided prior to exit from facility.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at			

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	least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure an available staff member was First Aid certified for 15 of 21 shifts scheduled. Findings include: Review of the facility staffing schedule for 3/17/24 to 3/23/24, provided by Administrator on 3/26/24 at 9:55 a.m., was completed on 3/27/24 at 2:30 p.m., and indicated 21 shifts were worked during this seven (7) day period. The following 15 shifts lacked an on-site staff member certified in First Aid: 3/17/24 - second and third shifts, 3/18/24 - second and third shifts, 3/19/24 - second and third shifts, 3/20/24 - second and third shifts, 3/21/24 - second and third shifts, 3/22/24 - first, second, and third shifts, 3/23/24 - second and third shifts. During an interview, on 3/27/23 at 2:30 p.m., the DON indicated she was not able to locate more employees certified in First Aid and she would look for the First Aid/CPR policies. A facility policy was not provided prior to exit.	R 0117	It is the intent of Sweet Galilee that perspective employees have the proper pre-employment licenses and certificates to work in our facility as required by 410 IAC 16.2-5-1.4(b). The deficiency had the potential to affect all residents. All current nursing employee files will be audited by 05/01/2024 by the DON/Designee to ensure they are certified in both CPR and Basic First Aid. All employees that are found to not be certified will be required to be certified by 05/01/2024. All future employees will be onboarded according to Gardant Management Solutions policy and will have the required pre-employment licenses and certifications prior to being employed by the facility. DON will be re-educated by the Regional Director of Clinical Services by 05/01/2024 on requirements for CPR and Basic First Aid according to state and federal guidelines. All required guidelines will be followed by facility going forward and no future employees	05/01/2024

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			will be allowed to work without required licenses and certifications. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that all required processes, policies, and guidelines are followed. Findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	
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 employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.			

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	(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. Based on record review and interview, the facility failed to ensure newly hired employees had general facility orientation for 2 of 6 employees reviewed for facility orientation. (QMA 8 and CNA 10). Findings include: A 3/26/34, employee record review, indicated the following employees lacked general facility orientation: a. QMA 8, start date 1/3/24. b. CNA 10, start date 9/5/23. During an interview on 3/27/24 at 2:30 p.m., the DON indicated she was not able to locate any further information for any of the missing employee documentation. The facility no longer had an employee in the Business Office Manager role who would be responsible to maintain the employee records. During an interview on 3/27/24 at 3:28 p.m., the Administrator indicated the facility did not have a specific policy for dementia training. Review of a current facility policy, revised 9/2015, titled, "Personnel Records", provided by the Administrator, on 3/27/24 at 3:19 p.m., indicated the following: "... Policy: Personnel records on all	R 0119	It is the intent of Sweet Galilee that perspective employees have the proper pre-employment screenings to work in our facilities as required by 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D). The deficiency had the potential to affect all residents. All current employee files were audited on 04/09/2024 by the business office manager to ensure they were compliant with Gardant Management Solutions policy. All files that were found to be out of compliance will be updated by 05/01/2024. All future employees will be onboarded according to Gardant Management Solutions policy and will be orientated appropriately with general and job specific materials. The facility will review all required documentation and ensure all new employees have been properly onboarded before working at the facility. Job specific orientation will be provided during the job specific orientation by the appropriate department head. A review of the pre-employment policy and orientation requirements will be	05/01/2024

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	Employees will be kept in a central location in the community...E. The following documents will be retained in the personnel rile or separate file as appropriate:...1. Application for employment. 2. Reference inquiry. 3. Orientation checklist. 4.TB testing results... 8. License...11. Job description...."		conducted with department heads by 05/01/2024 by the ED/Designee. All required procedures in the policy will be followed by facility going forward and no future employees will be allowed to work without required documentation. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that all required processes and policies are followed related to the hiring policy. This will be initiated and conducted by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	
R 0121 Bldg. 00	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			

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	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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (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. Based on record review and interview, the facility failed to ensure newly hired employees had health screens completed for 2 of 6 employees reviewed (QMA 8 and HHA 9), and newly hired employees received tuberculin skin tests or completed TB risk assessments for 2 of 6 reviewed for tuberculin screening (QMA 8 and CNA 10). Findings include: A 3/26/24, employee record review, indicated the following new employees lacked documentation of a health screen upon hire: a. QMA 8, start date 1/3/24. b. HHA 9, start date 12/18/23.	R 0121	It is the intent of Sweet Galilee that perspective employees have the proper pre-employment screenings to work in our facilities as required by 410 IAC 16.2-5-1.4(f)(1-4). The deficiency had the potential to affect all residents. All current employee files were audited on 04/09/2024 by the business office manager to ensure they were compliant with Gardant Management Solutions policy. All files that were found to be out of compliance will be updated by 05/01/2024. All future employees will be onboarded	05/01/2024

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	A 3/26/24, employee record review, indicated the following new employees lacked documentation of a tuberculin risk assessment screening and/or a Manitou (TB) skin test: a. QMA 8, start date 1/3/24. b. CNA 10, start date 9/5/23. During an interview on 3/27/24 at 2:30 p.m., the DON indicated she was not able to locate any further information for any of the missing employee documentation. The facility no longer had an employee in the Business Office Manager role who would have been responsible to maintain the employee records. Review of a current facility policy, revised 9/2015, titled, "Personnel Records", provided by the Administrator, on 3/27/24 at 3:19 p.m., indicated the following: "... Policy: Personnel records on all Employees will be kept in a central location in the community...E. The following documents will be retained in the personnel rile or separate file as appropriate:...1. Application for employment. 2. Reference inquiry. 3. Orientation checklist. 4. TB testing results... 8. License...11. Job description...."		according to Gardant Management Solutions policy and will receive the required pre-employment and post-employment health-related testing. A review of the pre-employment policy and orientation requirements will be conducted with department heads by 05/01/2024 by the ED/Designee. All required procedures in the policy will be followed by facility going forward and no future employees will be allowed to work without required documentation. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that all required processes and policies are followed related to the hiring policy. This will be initiated and conducted by the ED/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration			

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	number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure newly hired employees had job specific orientation for 1 of 6 employees reviewed for orientation (QMA 8) and newly hired employees had signed job descriptions for 1 of 6 employees reviewed for job descriptions (HHA 9). Findings include: A 3/26/24, employee record review, indicated QMA 8 lacked job specific orientation. The employee start date was 1/3/24. A 3/26/24, employee record review, indicated HHA 9 lacked a signed job description. The employee start date was 12/18/23. During an interview on 3/27/24 at 2:30 p.m., the DON indicated she was not able to locate any further information for any of the missing employee documentation. The facility no longer had an employee in the Business Office Manager role who would have been responsible to maintain the employee records. Review of a current facility policy, revised 9/2015, titled, "Personnel Records", provided by the Administrator, on 3/27/24 at 3:19 p.m., indicated the following: "... Policy: Personnel records on all	R 0123	It is the intent of Sweet Galilee that perspective employees have the proper pre-employment screenings to work in our facilities as required by 410 IAC 16.2-5-1.4(h)(1-10). The deficiency had the potential to affect all residents. All current employee files were audited on 04/09/2024 by the Business Office Manager to ensure they were compliant with Gardant Management Solutions policy. All files that were found to be out of compliance will be updated by 05/01/2024. All future employees will be onboarded according to Gardant Management Solutions policy and will be orientated appropriately with general and job specific materials. The facility will review all required documentation and ensure all new employees have been properly onboarded before working at the facility. Job specific orientation will be provided during the job specific orientation by the appropriate department head. A review of the pre-employment policy and	05/01/2024

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store, prepare, handle, and serve food in a safe, sanitary manner. This deficient practice had the potential to impact 90 of 90 residents who reside in the facility. Findings include: During an interview on 3/26/24 at 9:49 a.m., the Dietary Manager indicated the kitchen prepared meals for 90 to 91 residents.	R 0273	It is the intent of Sweet Galilee that all food preparation and serving areas be maintained in accordance with state and local sanitation and safe food storage handling standards as required by 410 IAC 16.2-5-5.1(f).The deficiency had the potential to affect all residents. Concerns cited in this deficiency were addressed as follows. Contents of open	05/01/2024

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	During an tour of the kitchen, accompanied by the Dietary Manager, on 3/26/24 from 9:49 a.m. to 10:05 a.m. the following concerns were observed: a. The walk in freezer contained an open box of dinner rolls, exposing the contents to the open air and an open box of mixed vegetables, with the contents exposed. During an interview on 3/26/24 at 9:53 a.m., the Dietary Manager indicated food items in the freezer should be contained in a closed container. b. The walk in fridge had a large, uncovered, sheet pan-sized cake on the bottom shelf. On 3/26/24 at 9:54, the Dietary Manager removed the cake, indicated it should be covered, and placed it on the food preparation area to be iced prior to lunch. c. The chest freezer, which contained ice cream, shrimp, and unknown boxes of food located under the ice cream, did not have a thermometer to monitor temperatures, nor a log to monitor temperatures. During an interview on 3/26/24 at 9:56 a.m., the Dietary Manager indicated the chest freezer should have a thermometer and log. It had been overlooked in error. d. The large table mounted can opener had a thick, sticky, multi-colored, layered residue on the cutting blade and base. During an interview on 3/26/24 at 9:59 a.m., the Dietary Manager indicated the can opener should be washed at least one time a day and appeared to have been accidentally over looked.		boxes and cake that was uncovered were disposed of. Audit of Refrigerator and freezer was conducted by dietary manager on 3/26/2024 to ensure no further issues were present. All dietary staff will be re-educated by Dietary Manger/Designee on Gardant Management Solutions' policies for General Food Preparation and storage as well as When to Wash Hands by 5/01/2024. The chest freezer had a new thermometer placed inside and will be monitored daily with a temperature log. Temperature log will be checked daily for completion by Dietary Mager/Designee. The blade on the large table mounted can opener was changed and will be cleaned after each use going forward. Dietary Manger/Designee will visually check for cleanliness each shift. All dietary staff will be re-educated by Dietary Manager on Proper hand washing and handling of food to prevent cross contamination by 5/01/2024. All dietary staff will also be re-educated on taking food temperatures prior to serving and recording the results. A weekly audit will be performed by Dietary Manager/Designee going forward to ensure deficiencies are not repeated and that the facility remains compliant. Findings will be reported to the Quality Assurance Committee. QAPI Committee will review audit for	

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		A. BUILDING 00 B. WING	03/27/2024

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	During a 3/26/24 lunch meal service observation, from 11:15 a.m. to 11:25 a.m., the following concerns were observed: Cook 6 was serving meal trays. She was wearing single use dietary gloves. With her gloved hands, she touched hand-written meal tickets, counter tops, drawer handles, serving utensils, and containers. With the same contaminated gloved hands, she touched and served baked bread, potato wedges, and grilled sandwiches. Although she did change her hands periodically during the meal service, she did not wash her hands prior to applying the gloves and when obtaining the gloves from their box she made contact with a large portion of the glove using her soiled hands. She then used those gloves to again make contact with baked bread, potato wedges, counters, containers, drawer handles, meal tickets, and utensils. While serving meals, she placed her thumb and at times fingers inside bowls and onto the food contact area of the plates. The practice of touching bowls, plates, and using contaminated gloves to serve food continued throughout the meal service. During an interview on 3/26/24 at 11:25 a.m., the Dietary Manager indicated food should be served using utensils such as tongs, scoops, and spatulas. Food should not be served using gloved hands. Hands should be washed each time before applying gloves. Meal tickets were taken throughout the dining rooms where staff members touch them and write on them with an ink pen. During an interview on 3/26/24 at 11:26 a.m., Cook 6 indicated she had not taken the temperature of the food items prior to serving the meal, and this was an error.		minimum of 6 months.	

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	During an interview on 3/26/24 at 11:28 a.m., the Dietary Manager indicated foods temperatures should be taken and recorded prior to meal service for every meal. At this time she provided the March 2024 Food Temperature Log for review. Multiple meals did not have temperatures recorded. The Dietary Manager indicated there were meals without recorded temperatures and this was an error. The March 2024 "Food Temperature Log" for March 1, 2024 through lunch March 26, 2024 had the following entries: a. 23 days of the 25 day review period did not have all three meals' temperatures measured. Five of these days had zero meals recorded: (3/3/34, 3/8/24, 3/12/24, 3/22/24, 3/26/24) A current, undated facility policy titled, "General Food Preparation," provided by the Administrator on 3/26/24 at 1:02 p.m., indicated the following: "...Food employees shall avoid direct contact (i.e., using bare hands) with ready-to-eat food whenever possible and to the extent possible, shall handle ready-to-eat food only with suitable utensils such as deli tissue, spatulas, tongs, or single use gloves. ... If gloves are used to handle ready-to-eat food, they should be single-use gloves...." A current, undated facility policy titled "When to Wash Hands," provided by the Administrator on 3/26/24 at 1:02 p.m., indicated the following: "...Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils,			

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	and unwrapped single-service articles, and:... f) During food preparation, as often as necessary- to remove soil and contamination when changing tasks... h) Before donning gloves for working with food...."			
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to coordinate service plans related to mental health needs with the resident's mental health care provider for 1 of 1 residents reviewed for mental health services (Residents 27). Findings include: Resident 27's clinical record was reviewed on 3/27/24 at 11:22 a.m. His diagnoses included schizophrenia, muscle weakness, and hypertension. The resident received Medicaid services. The resident received psychiatric services at a community-based provider.	R 0383	It is the intent of Sweet Galilee that all Mental Health Screening requirements as required in 410 IAC 16.2-5-11.1(g)(1-2) be met for residents in our care. The deficiency had the potential to affect all residents. DON coordinated with resident 27's mental health provider and has updated his care plan. Audit will be completed by DON/Designee before 5/01/2024 on all residents who are receiving mental health services to ensure that their care plans have been coordinated with	05/01/2024

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	The resident had a current, signed 1/22/24, Service Plan document. The service plan lacked a plan of care developed in cooperation with their mental health services provider to include the following: 1. Psychosocial rehabilitation services that are to be provided within the community. 2. A comprehensive range of activities to meet multiple levels of need, including the following: a. Recreational and socialization activities. b. Social skills. c. Training, occupational, and work programs. d. Opportunities for progression into less restrictive and more independent living arrangements. During an interview, on 3/27/24 at 2:35 p.m., the DON indicated Resident 27 had declined facility psychiatric services, was his own representative, and the facility had not reached out to his mental health provider. During a follow-up interview, on 3/27/24 at 2:45 p.m., the DON indicated the facility did not have a policy for residents with Major Mental Health illnesses.		their mental health service providers. All future residents who are admitted to the facility and refuse offered mental health services will be assisted in seeking other mental care provider services by DON/Designee. DON will then coordinate with those alternate mental health services to complete the resident's service plan. This process will be initiated and conducted by DON/Designee and will be ongoing. Findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.			

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	(4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to develop and implement an infection control program to track and trend infections. This deficient practice had the potential to affect 90 of 90 residents who resided in the facility. Findings include: During a record review, on 3/27/24 at 2:14 p.m., the Infection Control Binder, provided by LPN 4, lacked documentation of any resident infections for the year 2023. During an interview, at the time of the record review, LPN 4 indicated the facility only tracked respiratory infections as listed on the "Infection Prevention & Control" policy and this binder was where the infections for the building were tracked, except for COVID-19, which was tracked by another employee. Review of a current facility policy, dated 11/18/22, titled, "Infection Prevention & Control", provided by the Administrator, on 3/26/24 at 9:45 a.m., indicated the following: "...Policy: It is the policy of the community to prevent and/or minimize the spread of infectious diseases through infection control practices based on a variety of resources including but not limited to guidelines from The Centers of Disease Control and Prevention (CDC)...A. Determine before a resident is admitted or returns to the community, if Methicillin-resistant Staphylococcus (MRSA), Vancomycin-resistant entercocci (VRE), Norovirus, Influenza, or any other infectious disease is colonized or an active infection."	R 0407	It is the intent of Sweet Galilee that a developed Infection Control Program be in use as required by 410 IAC 16.2-5-12(b)(1-4). The deficiency had the potential to affect all residents. Facility developed and implemented a template to track and trend infections as required by State, Local, and Federal Regulations. This template has been added to the process already followed by the Gardant Management Solutions Infection Prevention and Control polies already used by the facility. DON/Designee will educate nursing staff on this new template by 5/01/2024. This new template will be audited monthly by DON/Designee as part of the facility's Quality Assurance Program and all findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for minimum of 6 months.	05/01/2024