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	05/12/2023

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: May 11 and 12, 2023 Facility number: 014706 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 16, 2023.	R 0000	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. Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective: 6/16/23 Sweet Galilee respectfully asks for Paper Compliance	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daphne New	Administrator	05/30/2023

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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	(E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to post contact information for advocacy and regulatory agencies. This deficient practice had the potential to impact 70 of 70 residents. Findings include: During an observation and tour of the facility on 5/11/22 from 10:08 a.m. to 10:45 a.m., a posting of contact information for advocacy and regulatory agencies was not located anywhere in the facility. During an observation of the lobby/entrance common area on 5/12/23 at 10:28 a.m., no posting of contact information for advocacy and regulatory agencies was locating in the common entrance area. During an interview on 5/12/23 at 10:30 a.m., the Receptionist indicated she did not know where a posting of contact information for advocacy and regulatory agencies was located. During an interview on 5/12/23 at 10:35 a.m., the Administrator made a tour of the lobby common area and could not locate a posting of advocacy and government regulatory agencies contact information. She made a phone call and queried the Activity Director. The Administrator then indicated the facility could not locate any posted contact information for the following: a. The Indiana Department of Health. b. The office of the secretary of family and social	R 0033	· *All residents have the potential to be affected by this deficient practice. A posting of mandated offices was hung in the lobby, consisting of: The ISDH, APS, The local Ombudsman, local Area on Aging, Office of FSSA and local Mental Health agency. * All residents will be made aware of the posting and familiar with the contents at the next resident council meeting. · *All residents will be provided with a copy of the posting, via memo delivered to apartment door. · *A posting shall be displayed at all times, in the common area of the lobby, in an area that is visible to residents and guests. The Administrator will include in monthly QA meeting for 3 months. · *The Administrator or designee will ensure the posting is available and visible by monitoring daily x's 3 weeks, then weekly x's 4 weeks and then monthly thereafter. · 5/31/23	05/31/2023

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	services. c. The area agency on aging. d. The local mental health center. e. Adult protective services.			
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure the residents had access to examine the results of the most recent annual survey of the facility conducted by the state surveyors and the plan of correction in effect with respect to the facility, and any subsequent surveys. This deficient practice had the potential to impact 70 of 70 residents who resided in the facility. Findings include: During an observation and tour of the facility on 5/11/22 from 10:08 a.m. to 10:45 a.m., no copy of the most current Indiana Department of Health annual survey results or plan of correction was posted anywhere within the facility. There was no signage indicating the location of the survey report. During observation of the lobby/entrance common area on 5/12/23 at 10:28 a.m., no copy of the most current Indiana Department of Health annual survey results or plan of correction was posted anywhere in the common area. There was no signage indicating the location of the survey report.	R 0042	· *All residents have the potential to be affected by this deficient practice. All residents will be made aware of the survey binder whereabouts and familiar with the contents at the next resident council meeting. · *All residents will be inserviced monthly, via Resident Council and monthly newsletter as to the whereabouts of the survey binder. · *The survey binder will be readily available at the reception desk or other designated location, at all times, for residents and guests of Sweet Galilee. The Administrator will include in monthly QA meetings for 3 months. · *The Administrator or designee will ensure that the binder is located in the designated location, daily x's 3 weeks, then weekly x's 4 weeks and then monthly thereafter.	06/05/2023

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	During an interview on 5/12/23 at 10:30 a.m., the Receptionist indicated the state survey results report was in a binder behind the counter and available upon request. During an interview on 5/12/23 at 10:35 a.m., the Administrator indicated the binder with the state survey results and was available upon request. The binder had frequently gotten lost when it was located in the common area. There was no sign telling the location of the survey results.			
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 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.			

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	Based on interview and record review, the facility failed to ensure one employee with First Aid Certification was on duty each shift for 18 of 21 shifts reviewed. This deficient practice had the potential to impact 70 of 70 residents who resided in the facility. Findings include: Review of the facility staffing schedule for 5/5/23 to 5/11/23 indicated 21 shifts were worked during this seven (7) day period. The facility provided a certification of "Standard First Aid" training for one (1) employ who worked three shifts during this seven day period. This resulted in 18 uncovered shifts as follows: 5/5/23- first, second, and third shifts, 5/6/23- second and third shifts, 5/7/23- second and third shifts, 5/8/23- first, second, and third shifts, 5/9/23- first, second, and third shifts, 5/10/23- first, second, and third shifts, 5/11/23- second, and third shifts. During an interview on 5/12/23 at 10:40 a.m., the Administrator indicated the facility did not have a record of any other employees, who had worked during the past week, having First Aid training. The facility was currently enrolling staff in both CPR and First Aid training.	R 0117	· *All residents have the potential to be affected by this deficient practice. Sweet Galilee had identified and already had classes scheduled. · *There will be at least one person per shift, daily, to be CPR as well as First Aid Certified. Sweet Galilee will continue to offer classes until standards are met or exceeded. · *Sweet Galilee will offer free CPR/First Aid classes to all of its employees, to ensure at minimum, one CPR and First Aid certified staff member per shift. · *The DON or designee will audit nursing employees monthly, to ensure they are first aid certified or attend a class. Include in monthly QA meetings x's 6 months or until 100% compliance is met.	06/16/2023
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.			

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	(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 2 of 2 residents reviewed for mental health services (Residents 48 and 54). Findings include: 1. During an interview on 5/12/23 at 11:53 a.m., Resident 48 indicated she had never been asked to participate, either in person or on the phone, in any type of meeting which involved the facility and her mental health provider in order to develop a plan to address her mental health needs. Resident 48's clinical record was reviewed on 5/11/23 at 2:30 p.m. Current diagnoses included schizoaffective disorder-bipolar type, anxiety and major depressive disorder. The resident received Medicaid services. The resident received psychiatric services at a community - based provider. The resident had a current, signed 9/6/22, 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.	R 0383	· *All residents with mental health diagnoses have the potential to be affected by this deficient practice. · *An audit will be conducted on all Residents to identify those with mental health diagnoses and to ensure they have appropriate service plans in place. Any missing mental health service plans will be corrected with the resident and resident's mental health provider. · *Monthly Service Plan meetings to audit resident service plans will be implemented to ensure compliance is met, ongoing. · *DON or designee will audit any new admits and include in monthly QA meetings for 6 months	06/16/2023

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	(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. 2. Resident 54's clinical record was reviewed on 5/11/23 at 2:10 p.m. Current diagnoses included schizoafffective disorder and legal blindness. The resident received Medicaid services. The resident received psychiatric services at a community - based provider. The resident had a current, signed 3/31/23, 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 5/122/23 at 10:37 a.m., the Administrator indicated the facility had not developed plans of care in cooperation with residents mental health care providers for Residents 48 and 54. An undated, current, facility document titled			

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	"Residents with major mental illness,", provided by the Administrator on 5/11/23 at 11:48 a.m. indicated the facility provided services to 13 residents with identified mental health needs. Residents 48 and 54 were included on the list. A current, 6/22/23, facility policy titled "Service Plans", provided by the Administrator on 5/12/23 at 10:37 a.m., indicated the following: "...C. The scope and content of the evaluation includes: 1. The resident's physical, cognitive, and mental status.... The services offered to the resident shall be appropriate to the scope, frequency, need, and preference of the resident...."			