STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutsonwood at Brazil	501 S Murphy Ave Brazil, IN 47834

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control measures when handling clothing and waste for prevention of transmission of multidrug-resistant organisms (MDRO) for 4 of 4 residents reviewed for infection control. (Residents B, C, D, and E). This deficient practice had the potential to affect 75 of the 75 residents residing in the facility.Findings include:During a random observation on 5/11/26 at 11:05 a.m., Receptionist 1 was observed walking out of Resident C and Resident D's room, wearing gloves and holding a pile of clothing in her hands. The clothing was not in a bag and would brush the front of her shirt as she walked. During the observation, Receptionist 1 indicated the clothing was some dirty clothes she was taking to the soiled utility. She indicated she could not find a bag to place them in, so she just donned gloves and was carrying them.1. During an interview on 5/11/26 at 11:50 a.m., Resident C indicated he had not observed staff putting on a gown when they entered his room to care for him. The staff do perform catheter care and bowel incontinent care with gloves on, but he had not observed them putting on a gown. When the staff collect his dirty clothing and linens, they carried it out using a clear plastic bag. He had not seen red bags being used.A record review for Resident C was completed on 5/11/26 at 1:30 p.m. Diagnoses included end stage renal disease, dependence on renal dialysis and benign prostatic hyperplasia.A change of condition Minimum Data Set (MDS) assessment, dated 2/19/26, indicated Resident C was cognitively intact and used a walker and/or wheelchair for mobility. He required substantial to maximum assistance of staff for bathing, dressing, transfers, and toileting. The resident was occasionally incontinent of bowel.A current health care plan with a start date 1/6/26, included Resident C required Enhanced Barrier Precautions (EBP) isolation related to colonized targeted MDRO and indwelling devices. Interventions included staff to wear gown and gloves, depending on bodily fluid exposure.A current health care plan with a start date of 1/28/25, indicated Resident C was at risk for complications related to renal failure and receiving dialysis. Interventions included to assess his shunt for bruit and thrill and to ensure shunt site dressing was clean, dry and intact.A current health care plan with a start date of 1/27/25, included activities of daily living functional status. Interventions included one staff member assistance for dressing/grooming, bathing, and transfer. The resident required the assistance of two staff members for bed mobility.A current health care plan with a start date of 2/4/25, indicated Resident C had altered bowel functioning as evidenced by frequent incontinence of bowel. Interventions included to assist with toileting transfer and hygiene as needed.2. A record review for Resident D was completed on 5/11/26 at 12:06 p.m. Diagnoses included obstructive and reflux uropathy and urinary retention.A quarterly MDS assessment, dated 4/10/26, indicated Resident D was cognitively intact and used a wheelchair or cane for mobility. He required staff supervision for showering and had an indwelling urinary catheter.A current health care plan with a start date of 1/6/26, indicated Resident D required EBP isolation related to colonized targeted MDRO and an indwelling device. Interventions included gown and gloves, depending on bodily fluid exposure.A current health care plan with a start date of 12/12/25, indicated Resident D was at risk of complications related to an indwelling catheter. Interventions included empty catheter bag every shift and as needed and measure and record output amount.A current health care plan with a start date of 12/17/25, indicated Resident D had impaired (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abilities to perform independent ADLs with bed mobility, transfers, and toileting. Interventions included to encourage resident and provide assistance as needed for bed mobility, toileting, and transfers.3. During an interview on 5/11/26 at 2:45 p.m., Resident B indicated staff members sometimes wore gloves when caring for her, but only a very few have put on a gown. The resident's spouse indicated he visits her everyday and had not observed staff putting on a gown. She had a needle in her left upper arm that she had received antibiotics for some infection in her urine.A record review for Resident B was completed on 5/11/26 at 11:33 a.m. Diagnoses included urinary tract infection and ESBL.A quarterly MDS assessment, dated 3/5/26, indicated Resident B had moderate cognitive impairment and used a wheelchair or walker for mobility. She required assistance from staff for toileting, transferring, showering, and dressing. She was frequently incontinent of bowel and bladder.A current health care plan with a start date of 9/26/25, indicated isolation related to infectious disease, Extended Spectrum Beta Lactamase (ESBL) resistance in urine. Interventions included following agency, state and federal guidelines for infectious disease, use protective equipment (mask, gown, gloves, goggles) as indicated, linen and trash barrels in room, and patient specific equipment in room (stethoscope, blood pressure cuff, thermometer.)A current health care plan with a start date of 7/15/25, indicated Resident B had impaired ability to perform independent Activities of Daily Living (ADLs) due to weakness and debility. Resident required extensive assistance from staff for bed mobility, transfers, eating, and toileting. Interventions included assist as needed for proper grooming, oral hygiene, nail care and toileting. Resident B required assistance from 1-2 staff to complete ADLs.4. During an interview on 5/11/26 at 3:04 p.m., Resident E indicated he had two bags on his abdomen that collect his urine and his stool. He indicated staff rarely, if ever, put a gown on to care for his ostomies. They do wear gloves. He indicated his dirty clothing was collected in a clear plastic bag. The bag and hamper were observed in the room with a clear plastic bag lining the hamper. He had not seen any red bags being used to collect his clothing or trash.A record review for Resident E was completed on 5/11/26 at 3:10 p.m. Diagnoses included end stage renal disease and dependence on renal dialysis.A quarterly MDS assessment, dated 3/5/26, indicated Resident E was cognitively intact and uses a walker or wheelchair for mobility. He required assistance of staff for bathing and dressing and had a urostomy and colostomy.A current physician's order, dated 1/6/26, indicated Enhanced Barrier Precautions Isolation. This order was not included in the resident's health care plan record.A current health care plan with a start date of 2/2/24, indicated Resident E was at risk for complications related to renal failure and receiving dialysis. Interventions included assessing shunt for bruit and thrill and to ensure shunt site dressing was clean, dry and intact.A current health care plan with a start date of 2/8/24, indicated Resident E required staff assistance for ADLs. Interventions included one staff assistance required for dressing and grooming, bathing, bed mobility and emptying his ostomies daily as needed. He requested the assistance of two staff for transfers.5. During an observation of the laundry rooms on 5/11/26 at 4:25 p.m., Laundry Aide 6 was observed folding blankets and towels. He was using his chest and abdomen to rest the blanket and towels on to fold them. During the observation, Laundry Aide 6 indicated he wore gloves when he sorted the dirty clothing for wash. The laundry did receive red bags of clothing and linens to wash separately from the clean bagged clothing and linens. He was trained to wear gloves when processing the red bags. He was not instructed to wear a gown or any type of barrier. He was not aware that some of the EBP resident laundry arrived in clear plastic bags. He had just started with the facility, and he had just finished orientation.During an interview on 5/11/26 at 4:46 p.m., the Housekeeping Supervisor indicated isolation linens should be placed in a red bag. The laundry staff were to gown and glove when handling this clothing and linens. Gloves should be worn during the sorting of all dirty laundry, not just the red bagged laundry. During an interview on 5/11/26 at 3:33 p.m., CNA 4 indicated she would don a gown and gloves prior to entering an EBP room to perform care that required close contact with a resident. She had placed dirty linens from these rooms in a red bag. She rarely had seen staff enter an EBP room requiring close contact care but had seen this happen.During an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 5/11/26 at 3:24 p.m., the Infection Preventionist (IP) indicated in any kind of isolation rooms, the resident's dirty clothing and linens should be placed in a red bag, and trash in a separate red bag. The DON indicated the clothing and linens received by laundry in red bags were washed separately from other residents clothing and linens.A current facility policy, revised 5/4/26, titled, Infection Prevention and Control Program, provided by the IP on 5/11/26 at 3:45 p.m., included the following: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Policy Explanation and Compliance Guidelines:.4. Standard Precautions:.c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.12. Linens: a. Laundry and direct care staff shall handle, store, process and transport linens to prevent spread of infection. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is completed the bag shall be closed securely and placed in the soiled utility room.A current facility policy, dated 1/15/26, titled, Enhanced Barrier Precautions, provided by the Administrator on 5/11/26 at 11:49 a.m., included the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Initiation of Enhanced Barrier Precautions:.b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i.indwelling medical devices (e.g., central lines, urinary catheters.hemodialysis catheters, PICC lines.ii. Infection or colonization with DCD-targeted MDRO when Contact Precautions do not otherwise apply.4. High-Contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care of use: central lines, urinary catheters.hemodialysis catheters, PICC lines.8. Additional epidemiologically important MDROs may include, but are not limited to:.b. ESBL-producing Enterobacterales. Guidelines for Environmental Infection Control in Health-Care Facilities (2003) was retrieved on 5/13/26 at 12:10 p.m. from the Centers of Disease Control (DCD website. The guidance included the following: .3. Collecting, Transporting, and Sorting Contaminated Textiles and Fabrics.Bags containing contaminated laundry must be clearly identified with labels, color-coding, or other methods so that health-care workers handle these items safely.This citation relates to Intake 3002456.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)