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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00369209. Complaint IN00369209 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F686, and F725. Unrelated deficiency cited at F888. Survey dates: April 28 & 29, 2022 Facility number: 000515 Provider number: 155608 AIM number: 100290820 Census Bed Type: SNF/NF: 83 SNF: 19 Total: 102 Census Payor Type: Medicare: 11 Medicaid: 58 Other: 33 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/5/22.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, related to medications not given as ordered for 1 of 3 resident reviewed for medication administration. (Resident D) Finding includes: Resident D's record was reviewed on 4/29/22 at 10:03 a.m. The diagnoses included, but were not limited to diabetes mellitus and left femoral endarterectomy with a left groin surgical site. The Physician Medication Orders included the following: On 2/16/22: Famotidine (stomach medication) 20 mg daily. Xarelto (anti-clotting) 20 mg daily. On 2/17/22: Gabapentin (nerve pain/anti-seizure medication) 100 mg (milligrams) twice a day. Glucosamine (supplement) 467 mg - chondroitin 438 mg - manganes 0.7 mg, two tablets daily. Isosorbide mononitrate ER (anti-hypertensive) 30 mg daily. Metformin (diabetic medication) 500 mg daily. Artificial Tears, 0.2% eye drops twice a day. Probiotic (supplement) 10 billion cell capsule, one daily. Senna with Docusate Sodium (laxative-stool softener) 8.6 mg - 50 mg, one daily. Vitamin B-12 (supplement) 1,000 microgram daily.	F 0684	Resident D had no negative effects as a result of the medications not documented as administered per physician's order. A review of all residents' medication administration records has been completed. For any like concerns identified, the physician and family have been notified and a medication error form has been completed if appropriate. The QMA was counseled for not documenting the administration of medications for resident D. Education has been completed for all nurses and QMAs related to ensuring all medications are administered as ordered by the physician and documented as such. The DON or designee will be responsible for running the missed medication reports after each shift for 1 month, daily for 1 month, weekly for 2 months and randomly for 2 months. Any identified concerns will be addressed immediately and brought to the QAPI committee for review for the 6- month period.	05/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	Vitamin D3 (supplement) 1,000 unit, daily. On 2/19/22: Vitamin E (supplement) 45 mg daily. Coenzyme Q10 (supplement), 400 mg daily. On 2/22/22, Norco (narcotic pain medication), 5 mg - 325 mg tablet, two tablets twice daily. On 3/2/22, ferrous sulfate (iron), 325 mg daily. On 3/9/22: Loratadine (post nasal drip) 10 mg daily. Flonase Allergy Relief 50 micrograms nasal spray, one spray each nostril twice a day. On 3/11/22, Rosuvastatin (cholesterol medication), 40 mg daily. On 3/15/22, Lisinopril (anti-hypertensive), 20 mg twice daily. On 4/2/22, a Physician's Order, indicated to give Pyridium (bladder) 100 mg three times a day. On 4/5/22, Mucinex (mucous congestion/cough) 600 mg twice a day On 4/8/22, metoprolol tartarate (anti-hypertensive) 50 mg, every 12 hours. Review of the Medication Administration Record, dated April 2022, indicated the gabapentin, glucoxamine, Isosorbide mononitrate ER, Lisinopril, Metformin, Artificial Tears, probiotic, Senna with docusate sodium, vitamin B-12, Vitamin D3, Vitamin E, Coenzyme, Norco, ferrous sulfate, and loratadine had not been administered on the morning on April 3 and 7, 2022.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	The morning dose of metoprolol tartrate was not administered on April 9, 12, and 13, 2022. The famotidine, Xarelto, Senna with docusate sodium, Norco, Pyridium, Flonase, Lisiniopril, Mucinex, and Rosuvastatin had not been administered at bedtime as ordered on April 9, 12, and 13, 2022. The Director of Nursing was interviewed on 4/29/22 at 11:52 a.m. She indicated she was unsure why the medications were not provided to the resident as ordered by the Physician. This Federal tag relates to Complaint IN00369209. 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure treatments for pressure ulcers and wound care were	F 0686	Resident D had no negative effects as a result of the treatments not documented as administered per	05/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	completed as ordered by the Physician for 2 of 3 residents reviewed for pressure ulcers and wound care. (Residents D and B) Findings include: 1. Resident D's record was reviewed on 4/29/22 at 10:03 a.m. The diagnoses included, but were not limited to, diabetes mellitus and left femoral endarterectomy with a left groin surgical site. An Admission Minimum Data Set (MDS) assessment, dated 2/20/22, indicated an intact cognitive status, required extensive assistance of two for bed mobility, and had one unstageable (full thickness tissue loss, which is covered by extensive necrotic tissue or by an eschar) pressure area on admission. A Care Plan, dated 2/23/22, indicated a risk for pressure ulcers. The interventions included, treatments would be completed as ordered by the Physician. A Care Plan, dated 2/23/22 indicated a risk for skin impairment. The interventions included, dietary supplements would be given as needed/recommended. a. A Physician's Order, dated 2/16/22, indicated skin repair lotion was to be applied on every shift to the bilateral feet. The Medication Administration Record (MAR), dated April 2022, indicated the skin repair lotion had not been applied as ordered on April 3, 6, 7, 8, and 10, 2022. b. A Wound Evaluation Form, dated 2/16/22, indicated a right heel pressure area with 1.1		physician's order. A review of all residents' treatment administration records has been completed. For any like concerns identified, the physician and family have been notified and a medication error form has been completed if appropriate. The nurse responsible for oversight of the QMA was counseled on the responsibility to ensure treatments were completed as ordered by physician and documented as such. Education has been completed for all nurses and QMAs related to ensuring all treatments are completed as ordered by the physician and documented as such. The DON or designee will be responsible for running the missed treatment reports after each shift for 1 month, daily for 1 month, weekly for 2 months and randomly for 2 months. Any identified concerns will be addressed immediately and brought to the QAPI committee for review for the 6-month period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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

centimeters (CM) by 1 cm of eschar (type of necrotic tissue) present.

The skin sheet, dated 4/12/22, indicated the right heel was 0.8 cm by 1.1 cm, necrotic with no change.

A Physician's Order, dated 2/17/22, indicated betadine topical solution was to be applied to the right heel after it was cleansed with normal saline and patted dry and left open to air daily on the 7 a.m. to 7 p.m. shift. .

The MAR, dated April 2022, indicated the betadine topical solution to the right heel had not been applied as ordered on April 3, 6, 7, 8, and 10, 2022.

c. A Wound Evaluation Form, dated 2/16/22, indicated there was a moisture associated skin damage (MASD) wound to the buttock, which was not measured. The skin sheets, dated 4/5/22 and 4/12/22, indicated the MASD was still present on the buttock.

A Physician's Order, dated 2/25/22, indicated the buttock was to be cleansed and Cavilon (barrier cream) was to be applied and allowed to dry, then a thin layer of Doudreaux's Butt Paste (zinc oxide) was to be applied to the buttock on the Day and Evening Shift.

The MAR, dated April 2022, indicated the Cavilon and Doudreaux's Butt Paste treatment to the buttocks had not been completed on April 2, 3, 6, 8, and 10, 2022 in the morning and April 3, 6, 8, 9, and 10, 2022 in the evening.

d. A Wound Evaluation Form, dated 2/16/22, indicated a surgical wound was present in the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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

groin, which measured 3 cm by 0.1 cm.

The left groin surgical site measured 2 cm by 0.1 cm on 4/5/22.

A Physician's Order, dated 3/3/22, indicated betadine topical solution was to be applied to the incision area (left groin), and cover with a gauze daily on the 7 a.m. to 7 p.m. shift.

The MAR, dated April 2022, indicated the betadine topical solution and gauze dressing had not been completed to the left groin incision on April 3, 6, 7, 8, and 10, 2022.

e. A Wound Evaluation Form, dated 4/5/22, indicated a laceration on the left great toe which measured 0.5 cm x 1 cm.

A Physician's Order, dated 4/6/22, indicated mupirocin ointment (antibiotic) was to be applied to the left great toe wound and covered with a dry dressing daily on the 7 a.m. and 7 p.m. shift.

The MAR, dated April 2022, indicated the mupirocin ointment and dry dressing to the left great toe wound had not been completed on April 6, 8, and 10, 2022.

f. A Physician's Order, dated 3/17/22, indicated Boost Glucose Control (supplement) was to be given daily in the morning to aid in wound healing.

The MAR, dated April 2022, indicated the Boost Glucose Control supplement had not been given on April 2, 3, and 7, 2022.

2) During an observation on 4/28/22 at 1:14 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	Wound Nurse 1 and Wound Nurse 2 completed Resident B's treatments. Wound Nurse 2 indicated the resident was admitted with a Deep Tissue Injury (DTI) (discolored intact skin due to damage of underlying soft tissue from pressure) on the buttock, which now had several small areas that were opened. She indicated the Wound Specialist consulted on the areas weekly and measured the areas as one wound. Wound Nurse 2 then measured the area as 6.9 cm by 2.9 cm. Both Wound Nurses indicated the area had improved. Wound Nurse 2 then applied sure prep (skin protectant) to the other DTI's on the right lateral foot, right lateral ankle, and right medial heel. Sure prep was also applied to a DTI on the left heel. The Physician's Orders, dated 4/20/22, indicated an order for skin prep to be applied to the left heel and to leave the area open to the air daily and skin prep was to be applied to the right lateral foot, right lateral ankle, and right medial heel DTI's every shift. The Treatment Administration Record, dated April 2022, indicated the skin prep treatments had not been completed as ordered on day shift on April 20 and 25, 2022. The Director of Nursing was interviewed on 4/29/22 at 11:52 a.m. She indicated she was unsure why the treatments were not provided to the resident as ordered by the Physician. A facility skin integrity policy, dated 12/4/18 and received from the Director of Nursing as current, indicated treatment to pressure ulcers and/or pressure injury would be provided. This Federal tag relates to Complaint IN00369209.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	3.1-40(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on interview and record review, the facility failed to ensure sufficient nursing staff was available to provide care and services to a resident, related to no Licensed Healthcare Provider scheduled to ensure pressure ulcer and skin integrity treatments were completed for 1 of 3 residents reviewed for care and treatment services for pressure ulcer and skin integrity. (Resident D)	F 0725	No residents were affected by the alleged deficient practice. The facility is confident that intentional scheduling by number of residents and resident needs will ensure that no residents are affected by the alleged deficient	05/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	Finding includes: Resident D's record was reviewed on 4/29/22 at 10:03 a.m. The diagnoses included, but were not limited to diabetes mellitus and left femoral endarterectomy with a left groin surgical site. An Admission Minimum Data Set (MDS) assessment, dated 2/20/22, indicated an intact cognitive status, required extensive assistance of two for bed mobility, and had one unstageable (full thickness tissue loss, which is covered by extensive necrotic tissue or by an eschar) pressure area on admission. a. The Wound Evaluation Form, dated 2/16/22 indicated a right heel pressure area, with 1.1 centimeters (CM) by 1 cm of eschar (type of necrotic tissue) present. The skin sheet, dated 4/12/22, indicated the right heel was 0.8 cm by 1.1 cm, necrotic with no change. A Physician's Order, dated 2/17/22, indicated betadine topical solution was to be applied to the right heel after it was cleansed with normal saline and patted dry and left open to air daily on the 7 a.m. to 7 p.m. shift. . The MAR, dated April 2022, indicated the betadine topical solution to the right heel had not been applied as ordered on April 6, 7, and 8, 2022. b. A Wound Evaluation Form, dated 2/16/22, indicated a surgical wound was present in the left groin, which measured 3 cm by 0.1 cm.		practice. Daily assignment sheets have been created to ensure that scheduled clinical staff have clear direction related to their work assignments and duties for the shift. These day sheets will include the responsible licensed professional or manager when a QMA is assigned. The aforementioned assignment sheets will be brought to the daily staffing meetings for review by the DON or Designee 5 days per week for 2 months and weekly for 2 months to ensure continued compliance. Any concerns identified in this review will be brought to the QAPI meeting for no less than 4 months to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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

The left groin surgical site measured 2 cm by 0.1 cm on 4/5/22.

A Physician's Order, dated 3/3/22, indicated betadine topical solution was to be applied to the incision area (left groin), and cover with a gauze daily on the 7 a.m. to 7 p.m. shift.

The MAR, dated April 2022, indicated the betadine topical solution and gauze dressing had not been completed to the left groin incision on April 6, 7, and 8, 2022.

c. A Wound Evaluation Form, dated 4/5/22, indicated a laceration on the left great toe which measured 0.5 cm x 1 cm.

A Physician's Order, dated 4/6/22, indicated mupirocin ointment (antibiotic) was to be applied to the left great toe wound and covered with a dry dressing daily on the 7 a.m. and 7 p.m. shift.

The MAR, dated April 2022, indicated the mupirocin ointment and dry dressing to the left great toe wound had not been completed on April 6 and 8, 2022.

On 4/29/22 at 11:52 a.m., the Director of Nursing (DON) indicated the resident had resided on the 100 hallway until April 7, 2022 and was then transferred to the 200 hallway on April 7, 2022.

On 4/28/22 at 12:15 p.m., the Nursing Schedules were reviewed for April 6, 7, and 8, 2022. The schedule on April 6, 2022, indicated on 100 hall, there was a QMA and 3 CNA's scheduled and on April 7, 2022, there was 1 QMA and 2 CNA's scheduled on 100 hall.

On April 8, 2022, there was 1 QMA and 2 Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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

CNA's scheduled on the 200 hallway.

There were no Licensed Nurses scheduled for the 100 hall on April 6 and 7, 2022 or on the 200 hall on April 8, 2022, to complete the resident's treatments as ordered.

The schedule reviewed had not assigned a nurse to complete the treatments on those days.

During an interview on 4/29/22 at 12:26 p.m., the DON indicated the Unit Managers were to assist with the treatments when a QMA was scheduled. She indicated when a QMA was scheduled on the 100 hall, the treatments were to be completed by the nurse scheduled on the 700 hall and when a QMA was scheduled for the 200 hall, the treatments were to be completed by the nurse scheduled on the 300 hall.

The schedules for April 6, 7, & 8, 2022 indicated on 4/6/22, there was one nurse and one CNA scheduled for the 700 hall. On April 7, 2022, there was one QMA and one CNA scheduled on the 700 hall.

The schedule for April 8, 2022 indicated there was one QMA and three CNA's scheduled for the 300 hall.

On 4/29/22 at 1 p.m., the DON indicated, when there was no nurse scheduled for the other hallway, then another nurse in the facility was to provide the treatments.

The Emergency Staffing Plan, dated 9/12/21 and received from the DON as current on 4/29/22 at 12:23 p.m., indicated Managers should be present when able to participate in primary care duties and staff could be rotated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	This Federal tag relates to Complaint IN00369209. 3.1-17(a)			
F 0888 SS=E Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;			
	Based on observation, record review, and interview, the facility failed to ensure staff who were unvaccinated implemented the facility's extra precautions for preventing the spread of COVID -19, related to wearing an N95 mask during their shift when residents were present, and being tested at least weekly for COVID-19, and that all employees received at least the first dose of a two dose COVID-19 vaccine series prior to working in resident care areas for 4 of 5 employees with exemptions or partially vaccinated status reviewed who worked on 3 of 6 halls. (Employees 4, 5, 3, and 6) Findings include: 1) During an observation on 4/28/22 at 7:59 a.m. Employee 5 was wearing a surgical mask and a face shield and was in a resident care area. Employee 5 indicated she was exempt from receiving the COVID-19 vaccination.	F 0888	Employee 3 has obtained a medical exemption. Employees 4, 5, 3, and 6 have been educated on the requirements to wear N95 in resident care areas and test at least weekly. A review of all employees, licensed practitioners, students, trainees, and volunteers as described in 483.80 has been completed to ensure they are aware of and are submitting to testing at least weekly and are wearing N95 in resident care areas. COVID status has been added to the HR on-boarding checklist. HR has been educated on COVID- 19 vaccination/exemption policy as it relates to pre-hire requirements. All staff identified as meeting the requirement have been educated	05/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	During an observation on 4/28/22 at 8:26 a.m., Employee 4 was in a resident care area. She indicated she was not vaccinated for COVID-19 and had an exemption. She was wearing a surgical mask and eye protection. She indicated she was not informed of any other extra precautions related to being unvaccinated, except she had to be tested at least weekly. Employee 5 was interviewed on 4/28/22 at 2:30 p.m. and indicated she had not been informed of any extra precautions she was to be doing due to not being vaccinated. Employee 4 worked on the 200 Hall and Employee 5 worked on the 700 Hall. 2) Employee 3's record was reviewed. The first dose of a two dose COVID-19 vaccination was administered 18 days after the employment at the facility had began. The Director of Nursing (DON) indicated on 4/29/22 at 3:27 p.m., Employee 3 worked in resident care areas (300 Hall) and Human Resources were responsible for tracking the new non-nursing employee's vaccination status. 3) Employee 6 was interviewed on 4/29/22 at 3:07 p.m. She indicated she had an exemption from the COVID-19 vaccination. An N95 was worn with eye protection. She indicated she had not been tested for a couple weeks and the facility had not informed her how often she was to be tested. Employee 6 worked on the 300 Hall. During an interview with the DON on 4/29/22 at 3:10 p.m., she indicated she was responsible for		on their responsibility for wearing N95 in resident care areas and testing at least weekly. A spread sheet has been developed that details employee, by department, their vaccination status, and their booster status. Managers will be responsible for ensuring their staff members are tested at least weekly and that they comply with N95 requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	tracking the COVID-19 testing. The DON indicated on 4/29/22 at 3:24 p.m., that Employee 6 had not been tested for COVID-19 for two weeks and due to the high transmission rate in the County, they were to be tested twice a week. The Facility COVID-19 Vaccination Policy, dated 2/3/22, and received from the DON as current, indicated employees with an exemption were to follow the infection control procedures outlined in the policy and submit to a weekly testing or as frequent as determined by applicable regulations. They must also wear an approved N95 or equivalent mask at all times, unless alone in an office, they can social distance, or when eating/drinking and social distanced. Employees must receive, at a minimum, a single-dose of the COVID-19 vaccine prior to providing any care or other services to the residents at the facility. 3.1-18(b)			