STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155522	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN ELWOOD, IN 46036

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00406083. This visit included a State Residential Licensure Survey. Complaint IN00406083 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 11, and 12, 2023 Facility number: 000372 Provider number: 155522 AIM number: 100289060 Census Bed Type: SNF/NF: 59 Residential: 16 Total: 75 Census Payor Type: Medicare: 7 Medicaid: 42 Other: 10 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 22, 2023.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations int he survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegations of compliance.	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental			

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

Penny Broshar | Administrator | 05/26/2023

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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	condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to ensure a significant change in a resident's status was included in a MDS (Minimum Data Set) assessment for 1 of 2 residents reviewed for MDS assessment (Resident 31). Findings include: During an interview, on 5/9/23 at 1:34 p.m., Resident 31's representative indicated the resident received hospice services. Resident 31's clinical record was reviewed on 5/12/23 at 10:07 a.m. Diagnosis included Alzheimer's disease, secondary malignant neoplasm of unspecified site, malignant related fatigue, and malignant neoplasm of ascending colon. A physician's order, dated 6/16/22 at 11:06 a.m., indicated hospice was to evaluate and treat. The resident's, 6/6/22, admission MDS (Minimum Data Set) assessment did not include hospice services. A 7/5/22 MDS assessment indicated hospice services. The clinical record did not include a significant	F 0637	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential to be affected by this deficient practice. All residents currently on hospice services were reviewed by corporate nurse to ensure significant change MDS was completed. MDS will be audited weekly by the corporate RN times 2 weeks or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and will be audited monthly by corporate RN consultant times 2 months or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and audited by corporate RN consultant quarterly times for one quarter or until 100% compliance is reached. Once this has been completed, we will bring to QAPI to discuss discontinuation of audit. MDS coordinator was educated on the guidelines for significant change MDS.	05/25/2023

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	change MDS assessment to reflect hospice services had started. A current care plan, dated 6/20/22, indicated the resident received hospice services related to colon cancer diagnosis. During an interview, on 5/12/23 at 2:04 p.m., the Clinical Support Nurse indicated the resident did not admit with hospice services and a significant change MDS assessment had not been completed. During an interview, on 5/12/23 ay 2:08 p.m., the MDS Coordinator indicated the RAI (Resident Assessment Instrument) manual was used as reference for completion of MDS assessments. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," version 1.17.1, dated October 2019, identified an SCSA as a Significant Change in Status Assessment and indicated the following: "...An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program...." 3.1-31(d)(1)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's have the potential to be affected by this deficient practice, The Business Office Manager or designee will communicate all hospice payer changes to the MDS coordinator and will be audited weekly by the corporate RN times 2 weeks or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and will be audited monthly by corporate RN consultant times 2 months or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and audited by corporate RN consultant quarterly for one quarter or until 100% compliance is reached. Once this has been completed, we will bring to QAPI to discuss discontinuation of audit. MDS coordinator was educated on the guidelines for significant change MDS. What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur? The Business Office Manager or designee will inform the MDS coordinator daily (Monday-Friday) of any payor source changes per	

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			census email. The BOM or designee will communicate all hospice payers changes to the MDS coordinator and will be audited weekly by the corporate RN consultant times 2 weeks or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and will be audited monthly by corporate RN consultant times 2 months or until 100% compliance is reached. BOM or designee to communicate all hospice payer changes to MDS and audited by corporate RN consultant quarterly for one quarter or until 100% compliance is reached. Once 100% compliance is noted, will bring to QAPI to discuss discontinuation of audit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur IE what quality assurance program will be put into place? Audits will be reviewed at the monthly focused QAPI for one year to ensure that this deficient practice does not reoccur.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately complete a resident assessment in the MDS (Minimum Data Set) for 1	F 0641	What corrective action(s) will be accomplished for those residents found to have been affected by the	05/25/2023

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	of 2 residents reviewed for MDS assessment (Resident 65). Findings include: During a closed record review, on 5/12/2023 at 3:28 p.m., Resident 65 was admitted on 2/23/2023 and discharged on 3/15/2023. Resident 65's MDS assessment dated 3/15/2023 was coded as "Discharged - Return Anticipated". Discharge Instructions dated 3/14/2023 indicated Resident 65 discharged to home, with continued therapy services at the facility. Review of a physician's order, dated 3/14/23, indicated "May discharge to home on 3/15/2023." During an interview on 5/12/2023 at 11:35 a.m., the MDS Coordinator indicated Resident 65 should have been coded as "Discharge - Return Not Anticipated." Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," Version 1.17.1, dated October 2019, indicated the following: "...Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response...."		deficient practice? All residents had the potential to be affected by this deficient practice. All discharge MDS from 5-24-23, will be reviewed by corporate RN to ensure accurate coding. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's have the potential to be affected by this deficient practice, All discharge MDS from 5-24-23 will be reviewed by corporate RN to ensure accurate coding times 12 months. What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur? All discharge MDS will be reviewed by corporate RN to ensure accurate coding. If deficiency is found during audit, the corporate RN will address immediately with MDS coordinator and correct. How the corrective action(s) will be monitored to ensure the deficient practice will not recur IE what quality assurance program will be put into place? Audits will be reviewed at the monthly focused QAPI for one year to ensure that this deficient	

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			practice does not reoccur.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure the low-temperature dishwasher was tested daily for wash temperature and sanitation levels. Of the facility's 59 residents, this deficient practice had the potential to affect 58 residents who received meals from the kitchen. Findings include: During a kitchen observation, on 5/8/2023 at 7:12 a.m., accompanied by the Dietary Manager, the sanitation log for the low-temperature dishwasher	F 0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential to be affected by this deficient practice. All dietary staff was in serviced on the proper policy and procedures for the dish machine. CDM will audit Dish machine Temperature Log daily (M-F) during normal business hours for	05/25/2023

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	was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed three times daily, and she regularly reminded staff to keep log current. The Dietary Manager attempted to test the low-temperature dishwasher, but indicated she did not know how to perform the test. She was unsure whether or not the strips she used were the correct strips. She could not complete test and would need to get her regular staff member to perform the test at a later time. During an interview on 5/11/2023 at 11:00 a.m., Dishwasher 5 indicated she regularly tested the low-temperature dishwasher, but she was not consistent about logging the testing of the dishwasher for sanitation and temperature. On 5/11/2023 at 11:11 a.m., the Dietary Manager indicated she relied on Dishwasher 5 to operate and test the low-temp dishwasher. They would also be relied upon to train new staff to operate and test the dishwasher. Review of a current facility policy, titled "Dish Machine Policy," dated January 1, 2022 and provided by the Dietary Manager on 5/9/23 at 10:30 a.m., indicated the following: "...Objectives: 1) Understand high temperature vs low temperature dish machines. 2) Understand how dishes are sanitized correctly. 3) Follow the manufacturer's instructions...." 3.1-21(i)(3)		compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident had the potential to be affected by this deficient practice. All dietary staff was in serviced on the proper policy and procedures for the dish machine. CDM will audit Dish machine Temperature Log daily (M-F during normal business hours) for compliance. What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur? CDM will audit Dish machine Temperature Log daily (M-F during normal business hours) for compliance for 2 weeks. When 100% compliance is reached, audit will decrease to 3 times a week for two weeks then weekly times two weeks then taken to QAPI and reviewed for discontinuation. After audit is complete, CDM will review the Dishmachine Temperature log daily on an ongoing basis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur IE what quality assurance program will be	

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			put into place? CDM will audit Dish machine Temperature Log daily (M-F during normal business hours) for compliance for 2 weeks. When 100% compliance is reached, audit will decrease to 3 times a week for two weeks then weekly times two weeks then taken to QAPI and reviewed for discontinuation. After audit is complete, CDM will review the Dishmachine Temperature log daily on an ongoing basis	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00406083. Complaint IN00406083 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 11, and 12, 2023. Facility number: 000372 Residential Census: 16 Elwood Health and Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed May 22, 2023.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations int he survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegations of compliance.	