STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN	20531 DARDEN RD SOUTH BEND, IN 46637

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00409312. This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy. Complaint IN00409312-Federal/State deficiencies related to the allegations are cited at F600. Survey dates: May 25 and 26, 2023 Facility number: 000073 Provider number: 155153 AIM number: 100288820 Census Bed Type: SNF/NF: 90 SNF: 5 Total: 95 Census Payor Type: Medicare: 8 Medicaid: 68 Other: 19 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed 6/5/2023.	F 0000	It is the intention of the facility to request a desk top IDR for survey findings F 600. 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 of any violation of regulation. Due to the relative low scope and severity of this survey post 5/26/23 when the facility was back in compliance, the facility respectfully requests a desk review in lieu of a post-survey revisit.	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

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.

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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review & interview, the facility failed to protect a resident's right to be free from neglect related to lack of timely, appropriate nursing interventions and services in response to a significant change in condition which resulted in the death of a resident for 1 of 3 residents reviewed for abuse/ neglect. (Resident B) The Immediate Jeopardy began on 5/22/2023 at 1:30 A.M., when the facility failed to ensure staff assessed and notified the physician of a resident who was found by a CNA to be exhibiting symptoms of acute distress and failed to initiate cardiopulmonary resuscitation (CPR) timely when found unresponsive.(Resident B) The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 5/25/2023 at 2:45 P.M. The Immediate Jeopardy was removed on 5/26/2023, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: The investigation of a facility reported death was reviewed on 5/25/2023 at 9:20 A.M. The investigation indicated on 5/24/2023 at 4:30 P.M., CNA 6 reported to the Director of Nursing that	F 0600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident expired and unable to apply a plan of correction for this resident. **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 residents of the facility have the potential to be impacted by the deficient practice. The nursing supervisor will round and review residents with the floor nurse to determine if there is a change of condition and submit a report to the Director of Nursing/designee at the end of the shift. Additionally, the interdisciplinary team will use a HIPPA compliant texting system to enhance communication as change of condition occurs. After 11 pm, the nurse supervisor will communicate urgent concerns via	06/19/2023

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	she had concerns with LPN 5's lack of care for Resident B on the night of 5/22/2023. The report indicated the Nursing Administration were able to verify CNA 6 had entered Resident B's room at 1:30 A.M. on 5/22/2023 and had exited quickly. LPN 5 did not enter Resident B's room to assess her until 5:07 A.M. At 6:00 A.M., a CODE BLUE was called, and CPR (Cardiopulmonary resuscitation) was initiated and 911 (emergency services) was called. The investigation indicated the "ambulance" took the resident and then returned with her deceased body and verified a time of death as 6:56 A.M. on 5/22/2023. During an interview and review of the facility reported death form,with the Director of Nursing on 5/25/2023 at 10:04 A.M., she corrected the date of CNA notification of the event to 5/23/2023 at 4:30 P.M. The DON indicated as she was speaking with CNA 6 regarding another issue, on 5/23/2023 at 4:30 P.M., she was informed of the aide's concerns with LPN 5. CNA 6 told her when she entered Resident B's room on the night of 5/22/2023, she heard "gurgling" noises coming from the resident and she immediately notified LPN 5. She indicated LPN 5 did not go assess the resident as she had requested. The DON indicated CNA 6 did not do anything more regarding her concerns. The DON indicated she had watched the facility's video footage and verified CNA 6 had entered Resident B's room at 1:30 A.M. on 5/22/2023 and then quickly exited. LPN 5 did not enter Resident B's room unit 5:07 A.M. The video footage showed LPN 5 going in and out of Resident B's room several times and then at 6:00 A.M. a CODE BLUE was called and other nursing staff and a cart with emergency supplies was brought to Resident B's room. The DON indicated the paramedics arrived soon after the CODE BLUE was called. She was notified of		phone to the appropriate individual i.e.; physician/nurse practitioner, Director of Nursing/Nurse leadership, and/or Administration. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Healthwin uses a HIPPA compliant texting system used to communicate physician notifications, change of condition to the physician and nurse practitioner. This is monitored by the Director of Nursing, Assistant Directors of Nursing, Administration as well as others in leadership roles. This is reviewed continuously throughout the day and night. After 11 pm, phone calls are to be made by the nursing supervisor for any concerns that would need to be addressed immediately and/or next steps to the Director of Nursing, Physician, Nurse Practitioner and Administrator. Additionally, the nurse supervisors will submit a report to the Director of Nursing/designee that ensures that the supervisors round on each unit and have eyes on the residents and review any change of conditions. Chart audits related to physician notification is completed by the Director of Nursing/designee to	

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	the CODE BLUE on 5/22/2023 at 6:19 A.M. The DON was interviewed regarding follow up interventions to the investigation and indicated after she was notified of the CNA's concern on 5/23/2023 at 4:30 P.M., she and her ADON, watched the video footage. After watching the video footage, the DON notified the Administrator of her concerns. The DON indicated she had attempted to call LPN 5, but she did not answer her phone. She indicated she had an education form ready for CNA 6 but had not given it to the aide because she had not been scheduled to work, since she had spoken with her on 5/23/2023. The DON indicated on 5/23/2023 at 10:00 P.M., she had the nursing night supervisor intercept LPN 5 at the time clock and escort her to their office. Once in the office, the DON had been called and the DON attempted to interview LPN 5 regarding the event the previous night involving Resident B. LPN 5 became very upset, started verbally "rambling" and the only concrete statement the DON could understand was "She's lying." The DON indicated she ended the interview and directed the night supervisory staff to terminate the employee and escort her from the building. The DON indicated there had not been any further action by the facility in response to the issue. The record for Resident B was reviewed on 5/25/2023 at 9:43 A.M., Resident B had been admitted to the facility on 5/11/2023 with diagnosis included, but not limited to: acute respiratory failure with hypoxia, s/p (status post) heart valve replacement, combined systolic and diastolic congestive heart failure and chronic obstructive pulmonary disease. The physician's orders for Resident B, completed on 5/11/2023, included an order for Full Code		determine outcome of the notification/change of condition, etc. If any physician notification is not resolved, the Director of Nursing/designee will follow up for completion and/or implementation of the physician notification. The nurse involved was terminated from the organization. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Nursing/designee reviewed the Nurse Supervisor's report on a daily basis. Results of the audits will be reviewed at QAPI on a monthly basis. Chart audits related to physician notifications will also be reviewed in QAPI on a monthly basis.	

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	status with full interventions. A copy of a POST (Physician Orders for Scope of Treatment) form for Resident B indicated the resident desired to have CPR and full interventions initiated. The form was signed by the physician on 5/13/2023. A Nursing Progress Note, dated 5/21/2023 at 5:18 P.M., indicated the resident was complaining of having difficulty breathing and a new order for oxygen at 2 liters was obtained. The note further indicated the resident's blood oxygen level was low (85 - 87 percent) so the oxygen was increased to 3 liters which raised the blood oxygen level to 92 to 97%. A Nursing Progress Note, dated 5/21/2023 at 6:00 P.M., indicated the physician was notified of the need for an oxygen order and a chest X-ray due to "congestion." A Nursing Progress Note, dated 5/21/2023 at 10:21 P.M, indicated an order for oxygen was received by the physician. A Health Status Note, dated 5/22/23, at 7:30 A.M., indicated,"... Resident noted to be congested. Biox-99%, no cough noted. HOB [head of bed] elevated, LS [lung sounds] with noted rhonchi [abnormal coarse], updraft [medicated respiratory treatment] given as ordered, tolerated. Resident after updraft still noted to be congested. This nurse went to get suction machine in case it is needed. When this nurse arrived back to the unit noted resident was unresponsive. VS [Vital signs-pulse, blood pressure, respiratory rate, temperature and blood oxygen level] taken-absent of VS. Resident is a full code, Code blue called. 911 was also called while code was started along with AED [automated external defibrillator] applied. EMS arrived and worked on resident for			

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	about 15-20 minutes and left with resident via stretcher to take her to Memorial Hospital. Family notified...." The nursing assessments, completed on 5/22/2023 indicated only a pulse had been obtained on 5/22/2023. The other vital signs, documented on the assessments, had been obtained on 5/21/2023 and had automatically pulled forward on the assessment form. There were no specific times of nursing actions related to the event in the nursing progress notes or in the assessments completed on 5/22/2023. The timing of the nursing progress note and assessments documented were after the resident's body had been returned to the facility. The Fire Department/Paramedic Incident Reports, from the two responding fire departments indicated they had been notified on 5/22/2023 at 6:09 A.M., by the nursing home of a female in cardiac arrest. When paramedics arrived, they found the resident lying in bed, unresponsive with facility staff performing CPR and utilizing an ambu bag (device to push air into mouth manually) to breathe for the resident, while the resident was in her bed. The paramedics from one department, placed the resident on the floor and continued "life safety measures" until the other fire department placed resident on stretcher and placed in an ambulance. The resident's body was warm to touch but her pupils were fixed and dilated. CPR continued for 30 minutes but the resident remained asystole (no heart beat) when CPR was stopped. CPR was stopped at 6:55 A.M. and the resident was returned to her room in the facility. During an interview with CNA 6, on 5/25/2023 at 3:11 P.M., she indicated on 5/22/2023 she had entered Resident B's room and noticed her			

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	breathing was making a "gurgling" sound. She indicated the resident was sitting upright in her bed with oxygen in place. CNA 6 indicated she asked Resident B if she was okay and Resident B nodded her head "Yes." CNA 6 indicated she left the room, without giving care and immediately told LPN 5. CNA 6 indicated LPN 5 just looked at her and did not go to assess Resident B. CNA 6 indicated she did not seek assistance from the nurse on a nearby unit, nor did she notify the Night Supervisor. CNA 6 indicated at some point during the night, she walked by Resident B's room and again noticed her breathing continued to emit a "gurgling" sound, so she again notified LPN 5. At approximately 5:00 A.M., CNA 6 entered Resident B's room and LPN 5 was already in the resident's room and LPN 5 was holding medications for her in her hand. CNA 6 indicated she left the room and completed her work, gave report to the nursing assistant replacing her and left the building around 6:00 A.M. CNA 6 indicated she was aware of how to contact the Director of Nursing and the Night Nursing Supervisor, but she had not attempted to contact them, even though she was concerned. Review of the current policy and procedure, titled, "Physician Notification", provided by the Director of Nursing, on 5/25/2023 at 2:16 P.M., indicated: "...1. Immediate Notifications: The nurse should contact the practitioner by phone for Immediate Notification items and must document the notification in the residents' chart. The nurse should notify the Supervisor, DON or ADON of the situation and then complete a Physician Notification. 2. Assessment (PN2) in PCC. The PN2 should include updated vital signs, pertinent labs, thorough assessment, and clear request. The Supervisor, DON, or ADON will send the assessment via Tiger Text in the "Urgent" group			

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	to the house practitioner as follow up notification for phone call placed. If the primary physician is an outside physician, the PN2 may be faxed to the physician's office....Signs and symptoms warranting Immediate Notification i.1.Sudden onset or worsening a. Shortness of breath...." The Immediate Jeopardy that began on 5/22/2023 and was removed on 5/26/2023 when the facility completed education regarding addressing change in resident conditions timely and notifying the nursing administration and physician timely of any significant resident condition changes, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy, because the shift rounding audit and the daily monitoring of physician orders and 24 hour reports to ensure timely physician and administrative notification of acute changes in condition had not been implemented at the time of survey exit. This Federal tag relates to complaint IN00409312. 3.1-27(a)(3)			