STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

(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 Complaints IN00401263, IN00400525 and IN00400173. Complaint IN00401263 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00400525 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656. Complaint IN00400173 - Unsubstantiated due to lack of evidence. Survey dates: February 8, 9, and 13, 2023 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 2 Medicaid: 44 Other: 11 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/23/23.	F 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for Desk Review and paper compliance.**	
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect			

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

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Bldg. 00	§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 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 interview and record review, the facility failed to protect a residents' right to be free from sexual abuse by a resident for 1 of 3 residents reviewed for abuse, (Resident C). Findings include: On 2/09/23 at 11:31 A.M., the Executive Director (ED) provided a facility reported incident, "Incident Number 686," dated 2/01/23. The report indicated on 2/01/23 around 7:00 P.M., staff were rounding in the Memory Care Area and found Resident D in bed with Resident C attempting to put his had down Resident C's brief. Staff immediately redirected Resident D and assisted him out of the bed and escorted him back to his room. A Head-to-Toe assessment was completed on Resident C, finding Resident C's brief remained in tact and fastened. Resident C did not show any signs or symptoms of psychosocial distress. On 2/09/23 at 11:47 A.M., the clinical record for Resident C was reviewed. Resident C was admitted on 7/19/21 with diagnoses that included	F 0600	F 600 Free from Abuse and Neglect **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of the facility to ensure all residents are free from Abuse and Neglect. Resident C and Resident D were immediately separated and no injuries or distress noted. Resident D was placed on 1:1 supervision and later moved from Memory Care unit to Long-Term Care unit. Resident D no longer resides at the facility per family wishes. **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:**	03/10/2023

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	but were not limited to Alzheimer's disease. The most recent comprehensive Minimum Data Set (MDS) was a quarterly assessment dated 12/22/22, and indicated Resident C was severely cognitively impaired, required extensive assistance for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. Resident C was totally dependent on staff for locomotion on and off the unit, and for bathing. The resident utilized a wheelchair for mobility. The MDS listed diagnoses that included but were not limited to, Alzheimer's disease, dementia, anxiety, and depression. On 2/09/23 at 2:00 P.M., the clinical record for Resident D was reviewed. Resident D was most recently admitted to the facility on 2/15/22 with diagnoses that included but were not limited to dementia with behavioral disturbances. The most recent comprehensive MDS was a quarterly assessment, dated 1/26/23, and indicated Resident D was severely cognitively impaired, exhibited intermittent signs of inattention, disorganized thinking, and altered levels of consciousness indicated by lethargy, difficult to arouse, and startling easily. The resident did not exhibit any behaviors to impact others during the 7 day assessment period. Resident D required limited assistance of 1 person to walk in the room and in the corridor and did not require a mobility device. The MDS listed diagnoses that included but were not limited to stroke and dementia. On 2/10/23 at 10:30 A.M., during an interview conducted with the ED she indicated it was inappropriate for Resident D to be in Resident C's bed. She indicated the facility policy directed the action to be a form of abuse, so reported the		All residents have the potential to be impacted by this deficient practice. All residents have been interviewed related to Abuse with no new findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff have been re-educated on Abuse Prohibition, Reporting and Investigation. ED to attend resident council with permission to discuss prevention and reporting of abuse. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Abuse Prohibition and Investigation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	incident to the State Agency within 2 hours of the occurrence. A policy, titled "Abuse Prohibition, Reporting, and Investigating," dated 1/23 was provided by the Executive Director on 2/09/23 at 2:50 P.M., and indicated it was the current policy. The policy indicated,"...It is the policy...to provide each resident with an environment that is free from abuse...This includes but is not limited to...sexual abuse...Definitions/Examples of Abuse...Sexual Abuse-Nonconsensual sexual contact of any type with a resident. Examples may include but not limited to...touching..." This Federal tag related to complaint IN00401263. 3.1-27(a)(1)		**By what date the systemic changes will be completed:** Compliance Date: 3/10/23	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview, and record review, the facility failed to implemented a Care Plan for a resident who required feeding assistance, for 1 of 3 residents reviewed for feeding assistance, (Resident B). Finding includes: On 2/10/23 at 12:13 P.M., during an observation of Resident B, the resident was in his bed with the head of the bed elevated and sitting up in	F 0656	**F 656 – Develop/Implement Comprehensive Care Plan** What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the	03/03/2023

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	preparation of the lunch meal, and with a Hospice nurse at the bedside. During an interview with the Hospice Nurse at that time, she indicated the resident required feeding assistance for all meals and that the resident spilled much of his food if he was not assisted. On 2/10/23 at 12:15 P.M., during an observation and interview, Resident B was set-up and awaiting the lunch tray. During an interview with the Executive Director at that time, she indicated Resident B required feeding assistance from the staff. On 2/10/23 at 12:30 P.M., during an observation of Resident B, the resident was being fed by Qualified Medication Aide (QMA) 3. During an interview with QMA 3, he indicated resident would sometimes feed himself, but was supposed to be fed by staff. On 2/13/23 at 10: 41 A.M.,during an interview with Social Service Director, she indicated on 1/27/23 there was a family Care Plan meeting with Resident B's family member and it was determined at that time that staff need to feed the resident and that resident Care Plans should be followed. On 2/13/23 at 2:20 P.M., the clinical record for Resident B was reviewed. Resident B was most recently admitted to the facility on 10/1/19 with diagnoses that included but were not limited to hemiplegia (paralysis to one side of the body) following a stroke, dysphasia (difficulty in swallowing), and contracture of the left hand. A Minimum Data Set (MDS) dated 11/05/22, for a quarterly assessment indicated Resident B was moderately cognitively impaired, exhibited no behaviors, required extensive assistance of 2		residents' goals and preferences. The care plan for Resident B has been reviewed and updated to include a care plan for activities. **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 have the potential to be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans will be completed and updated appropriately. Comprehensive Care Plan meetings will be held to ensure care plans are consistent with the residents' goals and preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Comprehensive Care Plan reviews will be completed for all residents upon Admissions and quarterly thereafter. ED or designee to meet with IDT members to review P & P for Comprehensive Care plan reviews. **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:**	

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	people for bed mobility, transfers, toileting, extensive assistance of 1 for dressing, personal hygiene, total dependence for locomotion on and off the unit, and bathing. The resident required supervision for eating. Resident B was receiving hospice services. Resident B's current care plans included but were not limited to, the resident's experience of weight loss in the past, dated 5/12/22. The Care Plan indicated staff were to monitor food intake at meals. A Care Plan for nutritional status was initiated on 10/02/19 and updated on 12/02/22, instructing staff to assist with eating as needed and to monitor food intakes. A CarePlan Summary dated 12/02/22, indicated in Culinary Instructions, "...discussed that when nurse does round she sees resident getting assistance with meals. Did speak with floor staff in regards to assisting res, [Resident B], not sitting tray in room without having staff ready to assist with meal..." A CarePlan Summary dated 1/27/23, indicated in Culinary Instructions, "...States staff should be feeding him [Resident B]...Nursing to offer to feed.." Review of Resident B's point of care documentation for meal assistance from 1/01/23 to 2/12/23 indicate the resident did not receive feeding assistance on the follow dates and times: 1/01/23 lunch: Independent 1/02/23 lunch: Independent 1/03/23 breakfast and lunch, no documentation 1/06/23 lunch: Independent 1/07/23 lunch: No documentation 1/09/23 breakfast: Independent		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 3/10/23	

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	1/10/23 breakfast: Independent 1/18/23 breakfast: Independent 1/22/23 breakfast: Independent 1/22/23 lunch: No Documentation 1/24/23 lunch: No Documentation 1/25/23 breakfast and lunch, no documentation 1/27/23 lunch: Independent 1/28/23 breakfast: Supervision 1/29/23 breakfast: Supervision 1/30/23 supper: No documentation 1/31/23 breakfast: Supervision 2/01/23 breakfast: Supervision. Lunch and supper, no documentation 2/04/23 supper: No Documentation 2/05/23 breakfast: Independent 2/06/23 breakfast: Supervision. Lunch, no documentation 2/07/23 breakfast, lunch, supper: no documentation. 2/08/23 breakfast, lunch: no documentation. Supper, supervision 2/09/23 breakfast, supper: no documentation 2/11/23 breakfast supper: no documentation 2/12/23 breakfast: no documentation Review of Resident B's Vitals Report for meal intake amounts from 1/01/23 to 2/12/23 indicated no meal intake documentation on the follow dates and times: 1/01/23 breakfast 1/02/23 lunch 1/03/23 breakfast and lunch 1/04/23 breakfast and lunch 1/05/23 breakfast and lunch 1/06/23 lunch 1/07/23 breakfast and lunch 1/08/23 dinner 1/10/23 lunch 1/12/23 lunch 1/18/23 lunch			

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	1/19/23 breakfast and lunch 1/20/23 lunch 1/24/23 lunch 1/26/23 lunch 1/28/23 lunch 1/29/23 dinner 1/30/23 breakfast and lunch 1/31/23 breakfast 2/01/23 breakfast and lunch 2/02/23 dinner 2/03/22 breakfast 2/05/23 lunch 2/06/23 breakfast 2/07/23 breakfast and dinner 2/08/23 breakfast and lunch 2/09/23 lunch 2/10/23 breakfast and lunch 2/11/23 lunch A policy titled, " IDT [Inter Disciplinary Team] Comprehensive Cafe Plan Policy," dated 10/19 and indicated as the current policy was provided by the Executive Director on 2/13/23 at 9:15 A.M. The policy indicated, "...The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning..." This Federal tag relates to complaint IN00400525. 3.1-35(g)(2)			