STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. BUILDING 00 B. WING	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

(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 was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: June 12, 13, 14, 17 and 18, 2024. Facility number: 001152 Provider number: 155658 AIM number: 200221050 Census Bed Type: SNF/NF: 94 Residential: 86 Total: 180 Census Payor Type: Medicare: 7 Medicaid: 78 Other: 9 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 1, 2024.	F 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on July 18, 2024.	
F 0604 SS=G Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for			

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

Gary BRENT Waymire | Executive Director / Administrator | 07/15/2024

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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	purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview and record review, the facility failed to ensure a consent with the identified medical reason for the use of a restraint was completed at the initiation of the restraint, to establish a time frame for continuing the use of the restraint and to establish how the restraint would be decreased and discontinued for 1 of 1 resident reviewed for restraints. (Resident 70) This deficient practice resulted in Resident C having three (3) falls with major injuries while using the restraint, had 3 emergency room evaluations and was diagnosed with nasal fractures, lacerations to her face which required sutures, and a laceration to her upper lip which required sutures.	F 0604	It is the policy of Wesley Manor to ensure a consent with the identified medical reason for the use of a restraint is completed at the initiation of the restraint, and to establish a time frame for continuing the use of the restraint and to establish how the restraint would be decreased and discontinued. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* Request/Screen for Rehabilitation	07/18/2024

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	Finding includes: During an observation, on 6/13/24 at 11:48 a.m., the resident was observed to be walking in a merry walker (a walker made of plastic PVC type tubing which enclosed the resident in the tubing frame and had a seat at the back of the frame). During an interview, on 6/17/24 at 11:09 a.m., the Director of Nursing (DON) indicated the resident was not able to get out of the Merry Walker on her own and it was considered a restraint. The clinical record for Resident 70 was reviewed on 6/14/24 at 9:59 a.m. The diagnoses included, but were not limited to, dementia with agitation, repeated falls, restlessness and agitation, anxiety, a psychotic disorder with delusions due to a known physiological condition, dementia with a behavioral disturbance, and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/24, indicated the resident utilized a physical restraint daily and the resident was severely impaired cognitively. A care plan, which was initiated on 10/24/22, indicated the resident was at risk for falls related to confusion, decreased mobility, and decreased safety awareness secondary to dementia. The goal was for the resident to be free of falls through the next review date. The interventions included, but were not limited to, assessing for injury when the resident sits on the floor, engaging in activities which improve strength, balance and posture, and keep areas free of obstructions to reduce the risk of falls or injury.		Assessment was requested for Resident #70, on June 19, 2024, by Physical Therapy, (see Attachment – 604-A). Resident seen by NP on June 19, 2024, and Physician's order obtained for medical need, (see Attachment – 604-B). Care Plan updated on June 19, 2024, to identify end of use of restraint, (see Attachment – 604-C). Physical Restraint Informed Consent updated on June 19, 2024, (see Attachment – 604-D). Prior to the implementation of the merry walker, this resident sustained twenty-two falls: seven falls resulting in minor injury, three requiring emergency department visits. While it is our objective to have no significant injury, the merry walker approach with monitoring by staff or family appears to the least resistive restraint and allows the resident to have some freedom of movement. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on June 19, 2024, for any resident who might utilize a restraint. The audit found no other residents affected. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur?	

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	A care plan, initiated on 11/2/22 and last revised on 6/19/23, indicated the resident was an elopement risk and would wander throughout the facility. The resident had a history of attempts to leave the facility unattended and had impaired safety awareness. The resident wandered aimlessly and significantly intruded on the privacy of others. The interventions included, but were not limited to, assessing for fall risk and distracting from wandering. A physician's order, dated 7/10/23, indicated for the resident to use a merry walker every 2 hours for gait release and to release the resident from the merry walker every 2 hours for toileting, hygiene, rest, food, and fluids. The resident was to be out of the merry walker at mealtimes and to attempt for the resident to sit in the dining room chair. There were no diagnoses or clinical indication for use documented on the physician's order. A progress note, dated 7/10/23, indicated the resident's daughter was called to discuss the use of a merry walker for the resident's mobility. The daughter was instructed that the resident would be released every 2 hours from the walker for 10 minutes. The safety of the resident while in the merry walker was discussed and the daughter agreed to the use of the Merry Walker. The progress note did not indicate the clinical rational for the use of the device, a plan to ensure the device was the least restrictive alternative for the least amount of time, when the ongoing need for the device would be re-evaluated and did not include the risks of using the device. There was no written consent signed by the daughter when the device was initiated. A progress note, dated 7/13/23 at 8:15 p.m.,		Wesley Manor's policy and procedure regarding ***"Restraints Use"*** was updated with a revision effective date of June 19, 2024, (see Attachment – 604-E). In-services were held on July 8, 2024, which covered the following topics: Restraint Use, Physical Restraint Reduction for Older Adults, obtaining weights, GDR and anti-psychotic usage, Thorough Investigations of Incidents, and Food Storage for residents and staff, In-Service Sign-In Sheet, (see Attachment – 604-F). Module 14. Physical Restraint Reduction for Older Adults, (see Attachment – 604-G). How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The IDT will review weekly during the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for any new restraint orders for the next three months and report to the QAPI Committee for the next Two Quarters. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	

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	indicated the resident had a witnessed fall while using the device. The CNA had observed the resident's merry walker tipping over a chair as the resident ran into it. The resident was lying face down in the merry walker. The resident had moderate bleeding from her nasal cavity. An Emergency Department discharge note, dated 7/13/23, indicated the resident had a fall and received a non-displaced fracture of the nasal bone, a facial hematoma, and a periorbital hematoma. A progress note, dated 7/13/23 at 10:30 p.m., indicated the resident returned to the facility from the Emergency Department and had bruising and swelling to her left eye lid, rug burns circling her left eye, and her nose was swollen. A facility fall note, dated 7/13/23, indicated the resident had a nasal bone fracture which occurred while in the merry walker. The walker tipped over a chair as the resident ran into the chair. The CNA was unable to reach the resident in time. The resident had a moderate sized hematoma above the left orbital cavity. The resident went to the Emergency Department and was diagnosed with a nasal bone fracture. A progress note, dated 7/14/23 at 10:06 a.m., indicated the fall was discussed with the resident's daughter. The anti-tippers for the merry walker were discussed. The progress note did not indicate the clinical rational for the use of the device, a plan to ensure the device was the least restrictive alternative for the least amount of time, when the ongoing need for the device would be re-evaluated and did not include the risks of using the device. There was			

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	no written consent signed by the daughter when the device was initiated. There was no documentation in the medical record to show the facility reassessed the resident for the appropriateness of the merry walker after her fall with injuries. A progress note, dated 7/26/23 at 9:00 a.m., indicated the staff talked to the resident's daughter about the safety and potential risks of the merry walker. The daughter was concerned a wheel would get stuck and tip the merry walker over. The staff reinforced to the daughter the anti-tippers were on each side and not the front or back of the merry walker. The resident was still a fall risk and still had the potential to tip the walker over. The resident would have staff supervision while in the merry walker and would be out of the merry walker every 2 hours at a minimum. A facility fall note, dated 1/23/24 at 11:10 a.m., indicated the resident had a fall at 10:40 a.m. The resident was face down on the floor in the merry walker. The CNA reported the resident's merry walker got caught on the corner of the wall by the nurse's station. The merry walker was laying on its side and the resident was laying on her right side. The resident was sent to the Emergency Department and returned at 3:40 p.m. The resident had three sutures on the bridge of her nose and two sutures to the upper lip. The daughter indicated she understood the risks of the merry walker. A hospital Emergency Department note, dated 1/23/24, indicated the resident presented to the Emergency Department after a fall. The resident was in her merry walker, and it flipped over causing her to fall face forward on the ground.			

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	The resident's injuries included mildly displaced bilateral nasal bone fractures, a small left frontal scalp contusion, a 0.5-centimeter (cm) laceration to the superior lip closed with two sutures and a 1.5 cm laceration on the nose closed with 3 sutures. There was no documentation in the medical record to show the facility reassessed the resident for the appropriateness of the merry walker after her second fall with injuries. A restraint informed consent, dated 3/4/24, was signed by the physician and the daughter. There was no written informed consent for the use of the merry walker located in the resident's medical record prior to the one dated 3/4/24. A facility fall note, dated 4/10/24 at 5:05 p.m., indicated the CNA reported the resident yelled for help and when she went to the resident, the resident was face down on the carpet, pushing herself up and rolling to her right side. There was blood coming from the resident's nose and mouth. The resident's merry walker was laying on its side by the resident. The resident had a laceration on her upper lip, facial abrasions to her forehead, chin and nose. The resident was sent to the Emergency Department and returned at 7:40 p.m., with 12 dissolvable sutures to her upper lip laceration. She also had an abrasion above her eyebrow, an abrasion to the bridge of her nose, and swelling to her nose. This was the third documented fall with injury to the resident while the merry walker was in use. A progress note, dated 4/11/24 at 10:46 a.m., indicated the daughter agreed the resident was only to be in the merry walker if the staff were able			

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	to be with the resident 1:1 or if the family was present. A physician's order, dated 4/11/24, indicated to use the merry walker with 1:1 or when family was present. Must release every 2 hours and as needed if still using 1:1 or with family for toileting, food, fluids and rest. The intervention of staff to be with the resident 1:1 did not occur until the third fall with injuries. During an interview, on 6/13/24 at 11:49 a.m., RN 3 indicated the resident was placed in the merry walker twice a shift. The Certified Nursing Assistants (CNAs) or the activity staff could help with the walker. The resident used the merry walker until she was tired and then the staff would remove the resident from the merry walker. During an interview, on 6/14/24 at 3:06 p.m., the Director of Nursing (DON) indicated the original consent for the merry walker was the verbal discussion with the daughter. The DON had verbal conversations with the daughter about the risks of the merry walker use. During an interview, on 6/17/24 at 10:09 a.m., the Assistant Executive Director (AED) indicated the physical therapist was in the quality assurance meetings when the merry walker was discussed but there were no assessments from the physical therapist (PT) for the use of the merry walker. During an interview, on 6/17/24 at 11:09 a.m., the Director of Nursing (DON) indicated the resident was not able to get out of the Merry Walker on her own and it was considered a restraint. There was no plan to stop using the merry walker which was considered a restraint. The first time the			

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	resident fell on 7/13/24 while using the merry walker, the anti-tippers were added to the walker. The resident was not supervised 1:1 until after the fall, on 4/10/24, and the intervention was put in place. During an interview, on 6/18/24 at 9:06 a.m., the daughter indicated she was not aware of the product the merry walker until the staff told her about it. Her mom would walk a few steps and then decide to sit down. At first, she was glad for the independence the merry walker gave her mom. After the first fall, anti-tippers were put on the walker, but they didn't work to keep her from falling. After the fall in April when her mom's tooth went through her mouth and she needed sutures, the daughter decided this was not working and her mom could only use the walker if someone was right with her to keep her from falling. Her mom did not understand she could not get into tight spaces, and this caused the falls. During an interview, on 6/18/24 at 2:33 p.m., the AED indicated the merry walker was a restraint and the facility thought this was the least restrictive device to be used to enhance the resident's life. The resident had zero safety awareness and was able to stand up and ambulate and was able to sit down in the seat of the merry walker. Without the merry walker, the resident would decline in her ability. There was no documentation in the electronic health record (EHR) to show this was the least restrictive device and there was no plan in the EHR to show a decrease or discontinuation of the restraint. The verbal plan would be to stop the restraint when the resident could no longer walk or bear weight since there would be a time in her disease process when she could not walk.			

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	During an interview, on 6/18/24 at 3:57 p.m., the AED indicated there was no written consent for the merry walker prior to 3/4/24. She was not able to provide documentation to show how often the use of the merry walker as a restraint was reviewed. A current policy, titled "Restraints Use," dated as last revised on 4/2/2009 and received from the AED on 6/17/24 at 11:00 a.m., indicated "...To ensure residents are provided a safe environment and that the use of restraints is carefully monitored to protect resident rights, personal comfort, and safety, assuring the least restrictive means are used...To use protective devices only when all other means of keeping a resident safe have been exhausted. The use of protective devices must be monitored in such a way as to minimize the impact on resident quality of life and functional status...To use protective devices or confinements only to treat medical symptoms in accordance with a physician's order and informed consent from the resident or responsible party...Initial assessment for the use of protective devices shall be followed by a monthly assessment for the first three [3] months and then quarterly assessments thereafter...Definition...Physical protective devices or restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily remove and that restricts freedom of movement or normal access to one's body...least restrictive measures...together with appropriate exercises and restorative nursing programs, shall be considered prior to the use of restraints...Care plan team participation in evaluation of restraint use and progress related to interventions and goals will be documented in the individual disciplinary progress notes...The			

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	interdisciplinary team, including specialized therapy staff, is responsible to participate in care planning interventions which may reduce or eliminate restraint use...Each physician's order for restraint shall be complete and specifically define the type, reason, duration, circumstances of restraint...If after a trial of alternative measures has been attempted and a determination that a physical restraint would enable and promote greater functional independence, or is necessary to provide lifesaving treatments, then the use of the restraint must first be explained to the resident, family member, or legal representative and written consent for use obtained...The care plan will reflect specific circumstances and medical symptoms for restraint use, time frames, and identify activities to occur during release periods...a licensed nurse is responsible for documenting, at least quarterly, in the nursed notes or on a physical restraint assessment the resident's response to the use of the restraint and goals identified in the plan of care and well as any attempt to reduce the use of restraints...." 3.1-26(a) 3.1-26(n) 3.1-26(o)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a thorough investigation was completed to include staff interviews after an injury of unknown source was identifed for 1 of 5 residents reviewed for accidents. (Resident 34) Finding includes: The clinical record for Resident 34 was reviewed on 6/14/24 at 11:12 a.m. The diagnoses included, but were not limited to Alzheimer's disease, dementia, unspecified intellectual disability, cognitive communication deficit, and other reduced mobility. A facility incident report indicated, on 4/7/24, there was bruising noted to Resident 34's right knee with swelling. The on-call nurse practitioner (NP) gave orders to do an x-ray as a precaution. X-ray results showed an acute fracture to the right hip and the bone was diffusely demineralized. A facility incident report with a follow-up added on 4/10/24, indicated on 4/6/24 at 10:00 a.m., the resident was observed to have swelling and her right leg appeared to be turned to the right. On 4/7/24, x-ray results came back and showed an acute right hip fracture. On 4/10/24, the Assistant Executive Director (AED) and Director of Nursing (DON) continued the investigation and demonstrated on the Maxi lift (a battery powered	F 0610	It is the policy of Wesley Manor to ensure thorough investigations are completed, and to include staff interviews after any injury of an unknown source. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* New policy written regarding Investigation Policy on June 20, 2024, (see Attachment – 610-A). *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on June 20, 2024, going back six months to review all “incidents” to assure that a thorough investigation had been completed. The audit found no other residents affected. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor’s policy and procedure regarding ***“Investigation Policy”*** was implemented on June 20, 2024.	07/18/2024

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	155658	A. BUILDING 00 B. WING	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

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	lift) where the placement of the sling landed, how it applied pressure when lifting a resident, and indicated this could have caused a pathological fracture. A physician's history and physical note, dated 4/11/24, indicated the resident was seen for medical necessity for a right hip fracture. The injury was most likely an osteoporosis fracture due to a maxi lift used and no documentation of a recent fall. During an interview, on 6/18/24 at 9:19 a.m., the Executive Director (ED) indicated she could not say for certain if the maxi lift being used instead of the Hoyer lift was the cause of the fracture. During an interview, on 6/18/24 at 9:54 a.m., the ED indicated there were no staff interviews the facility had conducted for the night shift staff who worked before the incident was noticed in the morning. The facility did not conduct interviews about how the resident was transferred with the staff who worked on the shift prior to when the injury was noticed. A current policy, titled "Fall Risk Identification/Fall Investigation," dated as last revised 12/6/19 and received from the AED on 6/8/24 at 3:50 p.m., indicated "...All falls and reports of potential risks shall be investigated and fall intervention implemented, as needed...." The facility did not provide a policy about investigating injuries by the time of exit. 3.1-28(d)		The Wesley Manor ***"Investigation Form"*** form was also revised as of June 20, 2024, to include a section to acknowledge the Witness and Resident Statement, (see Attachment – 610-B). In-services were held on July 8, 2024, which covered the following topics: Restraint Use, Physical Restraint Reduction for Older Adults, obtaining weights, GDR and anti-psychotic usage, Thorough Investigations of Incidents, and Food Storage for residents and staff, In-Service Sign-In Sheet, (see Attachment – 610-C). How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The IDT will review weekly during the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for any new reportable incidents for the next three months and report to the QAPI Committee for the next Two Quarters. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to cue and assist a resident during lunch according to the plan of care and to assess/reweigh a resident for a significant weight change for 1 of 4 residents reviewed for nutrition. (Resident 45) Finding includes: During an observation, on 6/12/24 at 12:13 p.m., Resident 45 was sitting up in a pedal Broda (chair for positioning) at the dining table with his eyes closed. His plate still had most of his food. The staff were not cueing or assisting him to eat. Most of the other residents in the dining room had already finished eating.	F 0692	It is the policy of Wesley Manor to cue and assist residents requiring assistance during meals according to the plan of care, and to assess/reweigh residents with significant weight change. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* A re-weight was done on June 17, 2024, with the resident weighing 130.6 lbs., a 4.4 lb. increase, and weighing again on June 26, 2024, weighing 130.6 lbs., (see Attachment – 692-A).	07/18/2024

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	During an observation, on 6/12/24 at 12:24 p.m., a female staff asked Resident 45 if he was hungry, and the resident shook his head for no. The resident was very thin. During an observation, on 6/13/24 at 12:05 p.m., Resident 45 was sitting in his pedal Broda at the dining table. The resident was not eating on his own and the staff were not encouraging or assisting the resident to eat. The staff were helping other residents to eat their lunch. During on observation on 6/14/24 at 12:07 p.m., Resident 45 was in his pedal Broda at the dining table, he was not eating. His silverware was still rolled up in the napkin and no staff was cueing or assisting the resident to eat. The staff were assisting residents at other tables. During an observation, on 6/14/24 at 12:37 p.m., Resident 45 was still sitting at the dining room table. The silverware was still wrapped up in a napkin and there was no staff assisting or encouraging the resident to eat. During an observation, on 6/17/24 at 11:39 a.m., Resident 45 was sitting up in his pedal Broda at the dining room table, his silverware was wrapped up in the napkin and his food was not touched. A female staff pushed the resident in his pedal Broda away from the table. The clinical record for Resident 45 was reviewed on 6/14/24 at 4:07 p.m. The diagnoses included, but were not limited to, unspecified dementia, type 2 diabetes mellitus, osteoarthritis, and cerebral infarction. A care plan, dated 2/22/24, indicated the resident		Resident added to the Nutrition at Risk, (NAR) program on June 28, 2024. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* All residents weighed on July 4, 2024. Any re-weight requested by the Registered Dietitian was obtained on July 5, 2024. The re-weights found no other residents affected. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor's policy and procedure regarding ***"Weighing Residents"*** was updated with a revision effective date of June 20, 2024, to delineate that re-weights will be completed within two days of Registered Dietitian or Interdisciplinary Team, (IDT) request, (see Attachment – 692-B). All Wesley Manor scales were recalibrated on June 25, 2024, (see Attachment – 692-C). In-services were held on July 8, 2024, which covered the following topics: Restraint Use, Physical Restraint Reduction for Older Adults, obtaining weights, GDR and anti-psychotic usage, Thorough Investigations of Incidents, and Food Storage for residents and staff, In-Service	

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	had an activities of daily living (ADL) self-care performance deficit related to dementia. The interventions included, but were not limited to, the resident required supervision by the staff to eat and may require limited to extensive assistance at times. A care plan, dated 2/27/24 and last revised on 5/28/24, indicated the resident had a nutritional or potential nutritional problem related to dementia, depression, underweight for age, and gluten intolerance. The goal included the resident would consume greater than or equal to 75% of his meals and the resident would have a gradual weight gain of 1-3 pounds each month. The interventions included, but were not limited to, observe/document/report signs of difficulty swallowing, choking, refusing to eat, monitor intake, and to observe/record/report significant weight loss of 3 pounds in one week, greater than 5% in one month, 7.5% in 3 months or greater than 10% in 6 months. An occupational therapy (OT) evaluation, dated 3/1/24, indicated the resident had a swan neck deformity (a bending of the base of the finger, a straightening of the middle joint and a bending of the outermost joint) in his right hand and his self-feeding may be impaired at times pending the food item. The resident presented with impairments in dexterity, strength and follow-through resulting in limitations and/or participation restrictions in self-care and general tasks. A physician's order, dated 5/27/24, indicated to give a regular diet, regular texture. The resident had a gluten sensitivity. A Registered Dietitian (RD) note, dated 5/27/24,		Sign-In Sheet, (see Attachment – 692-D). How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The IDT will review weekly during the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for any new residents with weight loss, or compromised as identified through the Nutrition at Risk, (NAR) Committee for the next three months and report to the QAPI Committee for the next Two Quarters. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	

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	indicated the quarterly nutrition assessment was completed. The resident had no significant weight change. The resident was referred to speech therapy and was referred to occupational therapy to assess the need for adaptive equipment. The resident had the following weights: 1. On 5/27/24, the weight was 133.6 pounds. 2. On 6/1/24, the weight was 126.2 pounds which was a 5.54% significant weight loss in 4 days. There was no documentation in the electronic health record (EHR) of a re-weight or assessment for the significant weight loss. During an interview, on 6/17/24 at 11:33 a.m., the Assistant Executive Director (AED) indicated the Nutrition at Risk (NAR) notes were not in the progress notes. The RD should have requested a re-weight on 6/1/24 and it might have gotten missed. The resident was not on the NAR although any re-weights would have been entered into the computer. During an interview, on 6/17/24 at 11:54 a.m., the RD indicated the resident did not trigger for a significant weight loss on 6/1/24 since it had not been 30 days. The RD had ordered a supplement of a magic cup on 5/27/24 since the resident's weight was not where she wanted it to be. The resident could usually feed himself with some cueing and sometimes his plate needed to be rotated so he could have better access to his food. A current policy, titled "Nutrition/Weight Loss/Gain," dated as last revised on 4/8/2010 and received from the AED on 6/17/24 at 3:56 p.m., indicated "...To establish methods for identifying concerns with residents' nutritional or hydration			

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	status and to guide facility staff to intervene as necessary to address any identified concerns...It is the policy of this facility to intervene when a resident has been identified as being at-risk for unplanned weight loss, and/or dehydration...Prevention...Care Planning/intervention will be established as appropriate...Monitoring...Staff will make observations regarding each resident's intake after meals...Intervention...When significant weight loss or significant weight gain has been observed, the following steps must be taken...Physician and family notification...Notification of the RD and/or Dietary Supervisor...Assessment of potential causes for the change...Interventions will be addressed on the resident's plan of care...." A current policy, titled "Nutrition Risk," dated as last revised on 1/24 and received from the AED on 6/17/24 at 3:56 p.m., indicated "...A Nutrition Risk team uses a systematic and interdisciplinary approach to identify, track, intervene, monitor, and follow-up with residents at high risk for significant weight changes, malnutrition, dehydration and pressure injuries, and any other nutrition-related concerns...Residents at nutrition risk will be reviewed the Interdisciplinary team [IDT]...The following criteria may be used to determine if a resident qualifies for Nutrition Risk...Unplanned significant weight loss/gain...5% in one month, 7.5% in 3 months, or 10% in 6 months...Significant change in appetite and/or decrease in usual oral intake in last 7 days...." 3.1-46(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs.			

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	§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			

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	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to provide documentation to show the resident specific psychosis/behaviors which were used as the rationale for declining a gradual dose reduction (GDR) of an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident 38) Finding includes: The clinical record for Resident 38 was reviewed on 6/14/24 at 10:40 a.m. The diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance, psychotic disorder with delusions due to a known physiological condition, severe major depressive disorder without psychotic features, and dementia with anxiety. A physician's order, dated 9/22/23, indicated to give risperidone (an antipsychotic) 0.25 milligrams (mg) three tablets one time a day for the psychotic disorder with delusions. A pharmacy GDR request, dated 3/1/24, indicated the resident received risperidone 0.75 mg daily and to please attempt a GDR of the risperidone to 0.5 mg daily. The physician response indicated the GDR was declined. The clinical rationale included the resident had intermittent episodes of delusional thinking and could be distressing. See the progress note dated 3/19/24. The progress notes were reviewed from 2/1/24	F 0758	It is the policy of Wesley Manor provide documentation to show the resident specific psychosis/behaviors which are used as rationale for declining a gradual dose reduction (GDR) of an antipsychotic. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* Corrected resident's behavior monitoring to include specific delusion monitoring on July 9, 2024, (see Attachment – 758-A). *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on July 9, 2024, for all residents with a diagnosis of delusions to include specific delusion monitoring. Seven additional residents were identified and behavior monitoring to include specific delusion monitoring was added, (see Attachment – 758-B). What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor's policy and procedure regarding	07/18/2024

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	through 3/18/24 and no resident delusions, behaviors or distress were documented in the progress notes. A psychiatric progress note documented by the Nurse Practitioner, dated 3/19/24, indicated the staff reported the resident continued with intermittent delusions which could be distressing. The resident had no evidence of delusional thinking or paranoia during her visit. A Care Tracker Behavior Monitoring and Interventions report, dated March of 2024, showed the Certified Nursing Assistants (CNAs) documented the following resident behaviors: 1. On 3/11/24 at 1:15 p.m., the resident was accusing of others. 2. On 3/11/24 at 1:16 p.m., the resident expressed frustration/anger at others. 3. On 3/19/24 at 1:37 p.m., the resident expressed frustration/anger at others. 4. On 3/19/24 at 1:38 p.m., the resident was agitated. The Behavior Monitoring and Interventions report did not include the interventions used, how long the behaviors lasted, if there were any delusions or the level of distress by the resident. It also did not include if a licensed nurse had to be involved with the resident's behaviors. There were no progress notes in the electronic health record to match the dates and times of the behaviors listed in the Care Tracker Behavior Monitoring and Interventions report. A care plan, dated 9/14/23, indicated the resident displayed delusional thoughts and told stories which were not factual. The interventions included, but were not limited to, attempt to		***"Medications: Psychotropic Drug Policy"*** was reviewed on June 20, 2024, with no update, (see Attachment – 758-C). In-services were held on July 8, 2024, which covered the following topics: Restraint Use, Physical Restraint Reduction for Older Adults, obtaining weights, GDR and anti-psychotic usage, Thorough Investigations of Incidents, and Food Storage for residents and staff, In-Service Sign-In Sheet, (see Attachment – 692-D). How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The IDT will review weekly during the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for any new resident with a delusion's diagnosis for the next three months and report to the QAPI Committee for the next Two Quarters. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	

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	redirect, don't argue, and ensure the resident's safety. During an interview, on 6/18/24 at 10:12 a.m., the psychiatric Nurse Practitioner (NP) indicated there was a behavior note on 3/19/24 which indicated the resident was sitting at the dining table waiting for an activity to start and she was upset and talking about her mom and dad. There were no other notes of behaviors on 3/19/24. There were no other progress notes with behaviors/delusions documented for February or March 2024. The resident could get easily upset at times although none of these behaviors were documented in the electronic health record. The staff had reported the delusions to her although the staff did not indicate how often or how the resident was distressed. A current policy, titled "Medications: Psychotropic Drug Policy," dated as last reviewed on 4/22/22 and received from the Assistant Executive Director on 6/17/24 at 3:56 p.m., indicated "...To develop/implement an interdisciplinary system to limit the use of psychotropic medications...to limit the use of psychotropic medications to only residents who have an appropriate supporting diagnosis and/or are exhibiting behavioral symptoms that indicate psychosocial distress and/or make the resident a danger to their self or others...remains committed to identifying the least restrictive intervention in order to treat the behavioral symptoms, which may include making changes in the environment, restructuring the resident's schedule, assessing the resident for acute causes for the behavior, or changing our approach to the resident...This policy includes a specific system for monitoring the use of psychotropic medications and reviewing the use of these medications			

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	periodically in attempt to reduce or discontinue our use of them if appropriate...When a resident exhibits a pattern of behavioral symptoms that indicate they are suffering psychological-related distress and/or are considered to be a danger to their self or others, staff must first ensure the safety of the resident and other residents...If psychotropic medications have been used to manage a resident's behavior, a plan must be developed to reduce or eliminate the use of this medication. This will include a behavioral intervention care plan. Attempts to redirect the behavior with less restrictive interventions must be documented in the resident's medical record...If a psychotropic medication [PRN or routine] is being used to treat a resident's behavior, then the specific behaviors for which the mediation is being used will be monitored daily and documented in the resident's treatment record...Anti-psychotic medications are approved for the following DSM indications...Medical illnesses or delirium with manic or psychotic symptoms and/or treatment related psychosis or mania...Diagnosis alone cannot warrant the use of anti-psychotic medication. Clinical condition must also meet the following...Symptoms are due to mania or psychosis...Behavioral symptoms present a danger to the resident or others...Symptoms are causing one or more of the following: inconsolable or persistent distress, a significant decline in function, and/or major difficulty in receiving needed care...." 3.1-48(a)(3) 3.1-48(a)(4)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. BUILDING 00 B. WING	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

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	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, interview and record review, the facility failed to ensure employee meals were not stored in the nutrition refrigerator, failed to ensure items were dated with open dates and labeled with a name, and failed to ensure thermometers were in the refrigerator/freezers for 3 of 10 nutritional and unit refrigerators observed for safe and sanitary conditions. Findings include: 1. During an observation, on 6/13/24 at 8:23 a.m., the First Floor Unit nutrition refrigerator, located in the medication room, was found to contain a lunch bag. At that time, LPN 1 indicated it was her lunch in the bag. Also found in the refrigerator was a 16-ounce open bottle of strawberry poppy seed salad dressing. The bottle had been opened and was found without an open date or a label	F 0812	It is the policy of Wesley Manor to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The following was done immediately during, or following the tours of the nursing units: 1 The lunch belonging to the LPN stored in the Fir Lane 1st Floor, (First Floor Unit Nutrition Refrigerator, located in the Medication Room) was moved to the Employee Break Room. The Director of Nursing verbally	07/18/2024

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	indicating who was the owner of the salad dressing. A sign found on the front of the refrigerator indicated "...This fridge is for ensures, pudding, applesauce's only. All Staff and resident food/drink items to be put in the fridges at either end of the hallway per state guidance...." During an interview, on 6/13/24 at 8:23 a.m., LPN 1 indicated the food storage policy, in the medication room nutrition refrigerator, was confusing. They posted the sign on the refrigerator, but the facility still allowed the storage of the items. During an interview, on 6/13/24 at 8:31 a.m., the Director of Nursing indicated the facility had an employee breakroom and the employee food items were to be stored in that refrigerator. 2. During an observation, on 6/13/24 at 8:33 a.m., the refrigerator found at the end of the hall, close to the elevator, on the first-floor unit was found to have 1-gallon of vanilla ice cream and a clear plastic zip lock bag containing frozen pastries. Both items were found without an open date or label to indicate who was the owner of the items. There was also no thermometer found in the freezer. The refrigerator contained an open 8-ounce bag of shredded taco cheese which had been opened and contained approximately 1-ounce of shredded cheese. There was no label to indicate the date the item had been opened or the owner of the items. There was no thermometer found in the refrigerator. During an interview, on 6/13/24 at 8:33 a.m., LPN 1 indicated there was no log to show the temperatures of the freezer or refrigerator had been monitored.		counseled the LPN regarding proper placement of employee meals. The 16 oz. bottle of strawberry poppyseed dressing was discarded. 2 Food items discovered in the Fir Lane 1st Floor refrigerator at the end of the hall, (First Floor end of hall located near the elevator), belonged to a residents' spouse, with the wife residing in the health care center and husband residing in assisted living. The Dining Services Director and Assistant Dining Services Director, with the husband present, discarded all items that were outdated and those items still within their manufacturers date were moved to the husband's AL apartment refrigerator. The refrigerator was removed from this area on June 13, 2024, by the Environmental Services team. 3 The Styrofoam container of ice cream found in the Fir Lane Ground Floor, (Ground Floor Refrigerator in the common area in front of the Nurses Station) was discarded. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on June 19, 2024, as directed by the Director of Nursing, by two Nurse – LPNs of all Nursing related refrigerators and no other issues were found, (see Attachment –	

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	During an interview, on 6/13/24 at 8:35 a.m., the Assistant Director of Dining indicated the dining staff did not know the refrigerator was on the unit/hall. The items should have been labeled/dated and the refrigerator and freezers should have had thermometers. During an observation, on 6/14/24, the refrigerator had been removed from the area. 3. During an observation, on 6/17/24 at 2:09 p.m., the refrigerator/freezer found in the common area in front of the nursing station was found to have a Styrofoam container of ice cream, with a plastic spoon upright in the ice cream, uncovered and without a date or label to indicated who was the owner of the ice cream. During an interview, on 6/17/24 at 2:12 p.m., RN 2 indicated the owner was unknown and the item should have been covered. A facility policy, titled "RESIDENT FOOD SERVICES," dated as last revised 1/24 and received from the Health Care Administrator on 6/13/24 at 10:30 a.m., indicated "...The outside food must be...clearly labeled with the resident's name, the date the food was brought to the resident, and the use-by date...." A facility policy, titled "RESIDENT FOOD SERVICES," dated as last reviewed 1/24 and received from the Health Care Administrator on 6/13/24 at 10:30 a.m., indicated "...Subject...UNIT PANTRY STOCK...Staff food...items are not stored in resident pantry refrigerators...All opened items must be labeled with opened and use-by-dates...." A facility policy, titled "Refrigerator Temperature		812-A) What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Executive Director and Associate Executive Director sent a memo to all Wesley Manor staff on June 13, 2024, regarding ***"Refrigerators – Use by Residents and Staff"***, (see Attachment – 812-B). In-services were held on July 8, 2024, which covered the following topics: Restraint Use, Physical Restraint Reduction for Older Adults, obtaining weights, GDR and anti-psychotic usage, Thorough Investigations of Incidents, and Food Storage for residents and staff, In-Service Sign-In Sheet, (see Attachment – 812-C), including the ***"Storage of Medications"*** Policy, (see Attachment – 812-D). How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The IDT will review weekly during the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for any issues with nursing unit refrigerators for the next three months and report to the QAPI Committee for the next Two Quarters. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	

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	Checks," dated as last revised 11/21/14 and received from the Health Care Administrator on 6/13/24 at 10:30 a.m., indicated "...Refrigerator...temperature checks should be documented on the form located on the front of the refrigerator...Temperatures should be documented at least daily...All open bottles and containers must have a "date opened" date on them...If no date is found on an open bottle or container, it must be discarded when found...." 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: June 12, 13, 14, 17 and 18, 2024. Facility number: 001152 Residential Census: 86 Wesley Manor Health Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on July 1, 2024.	R 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of	

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			Correction to be considered our Allegation of Compliance. Compliance is effective on July 18, 2024.	