STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155719	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 EAST STATE RD 16 BROOK, IN 47922

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 21, 22, 23, and 24, 2025 Facility number: 000559 Provider number: 155719 AIM number: 100267170 Census Bed Type: SNF/NF: 52 SNF: 4 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 40 Other: 14 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/28/25.	F 0000	February 4, 2025 Brenda Buroker Director, Long Term care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: POC for Survey Event ID 3X9511, for George Ade Memorial Health Care Center, Brook IN. Dear Brenda This is the plan of correction for the above-mentioned survey that was conducted on January 24,2024. This plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 14th of February,2025. At this time, we are requesting the Indiana State Department of Health conduct a tabletop review to clear the findings and stop all proposed and or implemented remedies that have been presented at this time. If you have any questions or need further information, please call (219)275-2531, and we will be glad to assist. Thank you, Scott James, HFA GAMHCC cc:file	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott James	HFA	02/06/2025

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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			The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.	

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F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to the staging of a wound for 1 of 17 MDS assessments reviewed. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 1/22/25 at 11:56 a.m. Diagnoses included, but were not limited to, dementia, pressure-induced deep tissue damage of the left heel, and unspecified soft tissue disorder related to use, overuse and pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/24, indicated the resident had moderate cognitive impairment, required maximum assistance with activities of daily living, and was diabetic. The skin assessment indicated the resident had two wounds to her left foot: a stage 3 pressure ulcer (a full-thickness wound that extends through the skin and into the fat below) to the ball of the foot, and a deep tissue injury (damage to the soft tissue and underlying structures beneath the intact skin) to the heel. The assessment indicated the resident was not at risk for a pressure ulcer / injury. The Wound Physician Notes, dated 12/12/24 and 12/19/24, indicated the resident had two wounds to her left foot: a diabetic wound to the ball of the foot, and a deep tissue injury to the heel. During an interview on 1/24/25 at 11:16 a.m., LPN 1 indicated she made an error on the wound record she provided to the MDS Coordinator. The	F 0641	A desktop review is requested for this tag. No other incidents were found to have actual harm. The MDS has been reviewed for accuracy as it pertains to the citing. No other actions were required. The MDS coordinator will continue to be checked for accurate input. See attachment The MDS coordinator or DON or designee will be responsible for seeing that this is being carried out to avoid further concerns. MDS nurse and wound nurse or designee will review and assure documentation is accurate. DON or designee will do a review of five residents, 3 times weekly for one month, 2 times weekly for another month, 1 time weekly for 2 months and QOW for two months with review by quarterly QAPI meetings. This is done as of 2/14/2025 compliance.	02/14/2025

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	resident had a diabetic wound, not a stage 3 pressure ulcer to the left foot. During an interview on 1/24/25 at 11:29 a.m., the MDS Coordinator indicated she used a wound record sheet from LPN 1 to complete the MDS assessments, and she should not have indicated the resident was not at risk for a pressure ulcer / injury on the MDS assessment.			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to a treatment not implemented timely for 1 of 3 residents reviewed for pressure ulcers. (Resident 30) Finding includes: On 1/24/25 at 1:38 p.m., the resident's left foot DTI (deep tissue injury) was observed with LPN 1. There was a small circular dark purple area about 1 cm (centimeter) x 1 cm to the bottom lateral side of the foot. The resident's record was reviewed on 1/23/25 at 1:08 p.m. Diagnoses included, but were not limited to, hypertension, cerebral infarction, and Alzheimer's disease. The Admission Minimum Data Set (MDS) assessment, dated 11/29/24, indicated the resident was cognitively impaired and had a current unhealed pressure ulcer/DTI. A Care Plan, updated 12/2/24, indicated the	F 0686	A desktop review is requested for this tag. No other resident was found to have actual harm as resulted to the citing. Upon further review, no other residents were found. Wound skin reviews are conducted weekly and followed up ongoing to ensure proper treatment and healing process review. The wound nurse is involved on a regular review on each resident found to be in need of treatment. See attachment. Nurse staff have been re-educated on pressure ulcer policy to assure proper treatment and documentation. DON or designee will do a review of five residents, 3 times weekly for one month, 2 times weekly for another month, 1 time weekly for 2 months and QOW for two months with review by quarterly QAPI meetings. This is done as of 2/14/2025	02/14/2025

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	resident had a DTI to his left lateral foot. The interventions included to treat per Physician's order. A Progress Note, dated 11/22/24 at 1:42 p.m., indicated the resident was a new admission to the facility. A dark brownish purple area was noted to his left foot. The Admission Observation, dated 11/22/24, indicated the resident had a pressure ulcer injury to the left foot outer aspect. It was brownish purple in color and measured at 0.8 cm x 3 cm. A Progress Note, dated 11/26/24 at 6:22 p.m., indicated a dry red maroon discoloration was observed to the resident's left outer foot. The edges were starting to lift. A new order was received for skin prep daily. A Physician's Order, dated 11/26/24, indicated to apply skin prep to the left outer plantar DTI daily. The Treatment Administration Record (TAR), dated 11/2024, lacked any treatment to the left lateral foot from 11/22/24, when the area was first noted, through 11/26/24. The skin prep treatment was first documented as completed on 11/27/24. During an interview on 1/23/25 at 2:15 p.m., the Director of Nursing (DON) indicated they should have put a treatment in place when they had identified the DTI upon admission. A facility policy, titled "Skin Condition and Pressure Ulcer Assessment," indicated, "...7. At the earliest sign of a pressure or other type of ulcer, or skin tear, resident, legal representative, and attending physician will be notified. The Director of Nursing will be notified daily using		compliance.	

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	24-hour condition report. The size and description will also be described in the nursing notes and a pressure or non-pressure event will be completed in the EMR..." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 3 residents reviewed for accidents. (Resident 52) Finding includes: On 1/21/25 at 11:23 a.m., Resident 52 was observed lying in bed. Her wheelchair was at her bedside. There were no anti-rollback bars noted to her wheelchair. On 1/22/25 at 2:53 p.m., Resident 52 was observed seated in her wheelchair in the hall near the Nurse's Station. There were no anti-rollback bars noted to her wheelchair. On 1/23/25 at 9:56 a.m., Resident 52 was observed seated in her wheelchair at the Nurse's Station. There were no anti-rollback bars noted to her wheelchair. The record for Resident 52 was reviewed on 1/22/25 at 1:14 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, and hypertension. The Significant Change Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident	F 0689	A desktop review is requested for this tag. No other residents were found to have actual harm. Falls and incidents involving falls have been reviewed. The information is reviewed on an ongoing basis with intervention implemented in each case. Residents are accessed for fall prevention upon admission and with each quarterly review or significant change in condition. See attachment. The DON or designee are responsible for seeing this is done on an ongoing basis. Nursing staff have been reeducated on the current fall policy and its application. DON or designee will do a review of five residents, 3 times weekly for one month, 2 times weekly for another month, 1 time weekly for 2 months and QOW for two months with review by quarterly QAPI meetings. This is done as of 2/14/2025 compliance.	02/14/2025

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	was cognitively impaired. She had one fall with no injury since the prior assessment and required partial to moderate staff assistance with bed mobility. A Care Plan, updated 12/31/24, indicated the resident was at risk for falls due to weakness and impaired mobility. An intervention, dated 11/26/24, indicated anti-roll back bars to wheelchair. A Progress Note, dated 11/25/24 at 11:44 a.m., indicated the resident was found sitting on the floor in the dining room. She was assisted back to her wheelchair by staff. The cameras were reviewed, and she had scraped her back and head on the table when she fell. An IDT (interdisciplinary team) note, dated 11/26/24 at 9:58 a.m., indicated the team had reviewed the resident's fall and anti-rollback bars had been applied to her wheelchair for safety. During an interview on 1/23/25 at 10:46 a.m., the Director of Nursing (DON) indicated there should have been anti-rollback bars on the resident's wheelchair. A facility policy, titled "Fall Prevention," indicated, "...The Interdisciplinary Team will use their initial assessment to determine how to provide the safest environment for each patient. Safety interventions will be initiated as needed for each patient...II. Fall risk interventions include:...F. Implement patient targeted interventions to reduce risk..." 3.1-45(a)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration for 1 of 2 residents reviewed for respiratory care. (Resident 4) Finding includes: On 1/21/25 at 2:36 p.m., Resident 4 was observed seated in his wheelchair in the hallway outside his room. He had no oxygen in place. On 1/22/25 at 2:52 p.m., Resident 4 was observed seated in his wheelchair in the hallway outside his room. He had no oxygen in place. On 1/23/25 at 9:55 a.m., Resident 4 was observed seated in his wheelchair in the therapy room. He had no oxygen in place. Record review for Resident 4 was completed on 1/22/25 at 1:17 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, and type 2 diabetes mellitus. The Annual Minimum Data Set (MDS) assessment, dated 1/7/25, indicated the resident was cognitively impaired and received oxygen therapy. A Care Plan, updated 1/7/25, indicated the resident had heart failure and chronic respiratory failure with a history of a pulmonary nodule. The interventions included to administer oxygen as ordered and as needed. A Care Plan, updated 1/7/25, indicated the	F 0695	A desktop review is requested for this tag. No other resident was found to have been harmed. Oxygen orders have been reviewed and changes made as needed to accurately show the current usage orders for resident with oxygen orders. See attachment. New and existing orders for oxygen are reviewed regularly and upon new physician order for accurate application. This is ongoing. The DON or designee is responsible to review orders for accurate administration. DON or designee will do a review of five residents, 3 times weekly for one month, 2 times weekly for another month, 1 time weekly for 2 months and QOW for two months with review by quarterly QAPI meetings. This is done as of 2/14/25 for compliance.	02/14/2025

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	resident was at risk for respiratory distress related to respiratory failure and hypoxia. The interventions included to administer oxygen as ordered. The Physician's Order Summary, dated 1/2025, indicated an order for oxygen 2-4 L (liters) per nasal cannula every shift. There were no other instructions or parameters listed. A Progress Note, dated 1/6/25 at 8:52 p.m., indicated the resident had a diagnosis of chronic respiratory failure with hypoxia and had an order for oxygen 2-4 L, which he refused during the day and sometimes at night. A Progress Note, dated 1/7/25 at 7:14 p.m., indicated the resident had a diagnosis of chronic respiratory failure and was oxygen dependent during the night only. The Medication Administration Record (MAR), dated 1/2025, indicated the oxygen had been signed off as administered every shift. An oxygen saturation was documented every shift, but the rate of oxygen administered was not documented. There were not any documented refusals. During an interview on 1/23/25 at 11:13 a.m., the Director of Nursing indicated she had updated the Physician, and the oxygen orders were now PRN (as needed). A facility policy, titled "Oxygen Therapy," indicated, "...12. Turn on liter flow to the ordered rate...18. Record oxygen therapy on the treatment or special record and nursing notes if PRN. Include type of catheter, liter flow, and response to treatment..."			

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F 0700 SS=D Bldg. 00	3.1-47(a)(6) 483.25(n)(1)-(4) Bedrails Based on observation, record review and interview, the facility failed to attempt alternative measures and assess the necessity for bed rails for 1 of 1 resident reviewed for bed rails. (Resident 52) Finding includes: On 1/21/25 at 11:23 a.m., Resident 52 was observed lying in bed. There were half length side rails to the top of the bed on both sides. On 1/21/25 at 1:41 p.m., Resident 52 was observed lying in bed. There were half length side rails to the top of the bed on both sides. The record for Resident 52 was reviewed on 1/22/25 at 1:14 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, and hypertension. The Significant Change Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident was cognitively impaired. She required partial to moderate staff assistance with bed mobility, was receiving hospice services, and bed rails were not used as a physical restraint. A Care Plan, updated 12/31/24, indicated the resident was at risk for falls due to weakness and impaired mobility. An intervention, dated 11/26/24, indicated to provide with safety device or appliance as needed. The Physician's Order Summary, dated 1/2025,	F 0700	A desktop review is requested for this tag. No other residents were found to be harmed by the citing. Residents have been assessed for bed rail usage and documentation has been put in the medical chart to reflect the same. See attachment. The need for bed rail usage will be reviewed quarterly and as needed to ensure appropriate use of same. The DON or designee will be responsible for this review. DON or designee will do a review of five residents, 3 times weekly for one month, 2 times weekly for another month, 1 time weekly for 2 months and QOW for two months with review by quarterly QAPI meetings. Done as of 2/14/2025 for compliance.	02/14/2025

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	lacked any orders for side rails. There was a lack of any evaluation or assessment completed for the use of side rails. During an interview on 1/23/25 at 11:13 a.m., the Director of Nursing (DON) indicated she was unable to find any assessment for the side rails but would have one completed now. She was unsure if any other interventions had been attempted prior to the side rails. On 1/24/25, the DON provided a Side Rail Assessment, dated 1/23/25. The bilateral top half side rails were to be used when in bed for assistance with transfers and bed mobility. A facility policy, titled "Side Rails," indicated, "...2. An assessment will be performed to determine if full length side rails are needed to treat medical symptoms. Use of full side rails require a Physician's Order. A one half side rail will be used in accordance with assessed need and resident desires..." 3.1-45(a)(2)			