STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00434526. Complaint IN00434526. - Federal/state deficiencies related to the allegations are cited at F600. Survey dates: August 7, 8, 9, 12 & 13, 2024 Facility number: 000359 Provider number: 155566 AIM number: 100274920 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 2 Medicaid: 40 Other: 27 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 8/21/2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 13, 2024 for the complaint survey completed August 13, 2024.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on record review and interview, the facility failed to implement effective interventions to prevent physical and verbal Resident to Resident abuse from recurring. This deficient practice resulted in Resident B exhibiting physically abusive behaviors which caused harm to 3 of 3	F 0600	F 600 Free from Abuse and Neglect It is the practice of this facility to ensure that each resident is free from abuse, neglect, and misappropriation of resident	09/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan A Jackson, HFA	Administrator	09/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	residents reviewed for abuse. (Residents C, D, & E) Findings included: 1. On 8/13/2024 at 1:37 P.M., a review of a facility reported incident 8/13/2024 at 1:37 P.M., indicated the following: "Incident date: 5/29/2024 at 6:30 P.M. Residents involved: Resident C with the diagnoses of dementia with mood disorder, depression and anxiety. Resident B with the diagnoses of Alzheimer's disease, psychotic disorder with delusions, depression and dementia with agitation. Description added: Staff alleged Resident B made contact with Resident C's shoulders and left forearm while ambulating in the Memory Care hallway. Action taken: Residents were immediately separated. Resident B was placed on 1:1 staff supervision. Nurse completed a skin assessment, no findings. Type of injury: Added 5/29/2024- Discolored areas noted to Resident C's left forearm. Type of preventative measures added 5/29/2024 - blank.." The record for Resident B was completed on 8/13/2024 at 1:07 P.M. Diagnoses included but were not limited to anxiety, depression, psychotic disorder with delusions, dementia with agitation, and Alzheimer's disease. The Nursing Progress notes included and Incident Note, dated 5/29/2024 at 6:15 P.M.,which indicated the staff alleged the resident made physical contact to the shoulders of Resident C. The Residents were immediately separated, and Resident B was placed on one on one supervision.. Nursing Progress notes included A Nature of Trauma Note, dated 5/30/2024 at 11:15 A.M.,		property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Resident B was transferred to another SNF per family request. Resident C, D, and E returned to baseline and had no recollection of the events that were mentioned. **How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents who demonstrate behaviors have the potential to be affected by the alleged deficient practice. Any event that has been reported since the survey exit has been reviewed to ensure appropriate, person-centered interventions are in place based on the root cause if able to be determined. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The policy “Abuse Policy” will be reviewed by the IDT. An in-service will be held with the IDT on the policy, specifically related to abuse prevention. All progress notes will be reviewed during clinical morning meeting and any resident behavior changes will be updated on the care plans. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	which indicated "Resident B put this hands on another resident (Resident C) and left bruises on her arms. Identify triggers: No known triggers. Interventions: Removed from triggering event. Notified IDT team. Notified resident representative when appropriate. Response to Interventions: Unable to recall event. Additional interventions: blank." Resident B was discharged to a Psychiatric hospital on 5/30/2024 and returned on 6/11/2024. The record for Resident C was completed on 8/8/82024 at 2:13 P.M. Diagnoses included, but were not limited to dementia, anxiety, depression and psychotic disorder. Resident C utilized a wheel chair and walker for mobility. A Behavior Note for Resident B, dated 6/16/2024 at 3:05 P.M., indicated he had returned from an outing with his family. Resident B's wife reported the resident was belligerent and had threatened to "kick peoples a---" at the bowling alley. A Trauma Evaluation Note for Resident B, dated 6/17/2024 at 7:10 A.M., indicated: he had grabbed another resident's walker and then shoved it into her when she would not let go, which caused the other resident to fall to the floor backwards. Identify Triggers: "This resident was already agitated, but all the other resident did was walk by him. Interventions: Removed from triggering event. Notified IDT team. Notified physician. Notified resident representative when appropriate. Response to Interventions: Unable to recall event. No change from baseline..." An Incident Note, dated 6/16/2024 at 4:10 P.M., indicated he had made physical contact with a peer as Resident B resident was walking past in		performance improvement tool has been developed to audit any resident-to-resident incidents, including review of the root cause of the incident as well as a new intervention being implemented for each occurrence. **How the corrective actions will be monitored to ensure the deficient practice does not recur;** A performance improvement tool has been initiated that audits each resident-to-resident occurrence to ensure a root cause was identified and an immediate intervention was put in place. This performance improvement tool will be completed by the Director of Nursing/ Designee on each occurrence for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **By what date the systemic changes will be made 9-13-24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	the hallway on the memory care unit which resulted in the peer falling. An Incident Note, dated 6/16/2024 at 4:10 P.M., indicated Resident B was placed on one on one monitoring. Resident B was discharged to a Psychiatric hospital on 6/18/2024 and returned on 7/1/2024 A Nursing Note for Resident B, dated 6/21/2024 at 4:49 P.M., indicated the family was notified of Resident B's possible return on the 25 th. The family was concerned the facility stated he would be returning Thursday and the psychiatric hospital had done nothing for him because they could only treat the resident for behaviors that were seen while Resident B was at the hospital. A Behavior Note for Resident B, dated 7/1/2024 at 3:01 P.M., indicated staff alleged that he made physical contact with the left cheek of another resident, after the resident made accidental contact with her walker to his foot. A Behavior Note for Resident B, dated 7/3/2024 at 4:38 P.M., indicated he had been verbally aggressive with staff and other residents. A Behavioral Health Progress Note, dated 7/8/2024, indicated Resident B had been referred to behavioral health to establish the necessity for continued psychotherapeutic and neurocognitive assessment services via the Behavioral health provider to address cognitive and neuropsychiatric symptoms." ...{Resident name} is back from his psych stay, but staff report ongoing behaviors and is easily agitated which he then can become aggressive...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	A Behavior Note for Resident B, dated 7/10/2024 at 6:20 P.M., indicated he had been verbally abusive to staff and other residents most of the shift. Resident B was walking up and down the unit yelling and threatening staff, stating,"Keep it up and I am going to put my fist around your face." A Physician's Progress Note, dated 7/18/2024, indicated a routine follow up visit for Resident B had been completed. Staff reported the resident would be transferring to another facility either later today or tomorrow. 2. A Behavior Note for Resident B, dated 7/22/2024 at 6:15 P.M., indicated staff alleged he approached Resident D and made physical contact with her right cheek with a photo album. The occurrence was unprovoked by Resident D. A facility incident report, dated 7/22/2024, indicated: "Incident date: 7/22/2024 at 6:15 P.M. Residents involved: Resident D with the diagnoses of vascular dementia, depression, and delusional disorder. Resident B with the diagnoses of Alzheimer's disease, psychotic disorder with delusions, depression and dementia with agitation. Description added: Staff allege Resident B approached Resident D and made contact with Resident D's right cheek with a photo album. The incident was unprovoked by Resident D. Action taken: Residents were immediately separated. Resident B was offered an activity of interest. Type of injury: None. Type of preventative measures added: Investigation initiated. Pertinent information to be included in the 5- day follow-up. Follow up added: Let this serve as follow up to the incident. Staff allege Resident B approached Resident D and made contact with her right cheek with a photo album.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	The incident was unprovoked by Resident D. Residents separated. Resident B was offered and activity of his interest. It was effective. Neither resident recalled the incident and returned to their baseline. Care plans have been updated...." A Trauma Evaluation Note for Resident B, dated 7/23/2024 at 9:01 A.M., indicated: " Nature of Trauma: Resident B approached Resident D with a photo album in his hand, and proceeded to use it to hit Resident D's face. Identify Triggers: Non known triggers. Interventions: Removed from triggering event. Notify IDT team. Notify resident representative when appropriate. Response to Interventions: Unable to recall event. No change from baseline. Additional interventions: blank...." 3. A facility incident report, dated 7/28/2024, indicated: "Incident Date: 7/28/2024 at 5:10 P.M. Residents involved: Resident E with the diagnoses of depressive disorder, dementia, delusional disorder, traumatic brain injury and insomnia. Resident B with the diagnoses of Alzheimer's disease, psychotic disorder with delusions, depression and dementia with agitation. Description Added: Staff allege Resident B entered Resident E's room without being asked in. Resident E attempted to push Resident B out of the room. Resident B then made contact with Resident E's right cheek and Resident E made contact with Resident B's forehead. Action Taken: Residents were immediately separated. Nurse completed skin assessments of both residents. Resident B was offered and activity of interest and was effective. No findings. Family, physician and police were notified...." A Behavior Note for Resident B, dated 7/28/2024 at 5:10 P.M., indicated: staff allege that Resident B			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	entered Resident E's room without being asked. Resident E attempted to push Resident B out of the room. Resident B then made contact with Resident E's right cheek and Resident E made contact with Resident B's forehead. A Trauma Evaluation Note for Resident B, dated 7/29/2024 at 12:41 P.M., indicated:" Nature of Trauma: Resident B went into Resident E's room uninvited, and when Resident E tried to ask Resident B to leave, Resident B swung at him and Resident E swung back. Identify Triggers: being asked to leave a room he didn't want to leave. Interventions: Removed from triggering event. Notify IDT team. Notify resident representative when appropriate. Respond to Interventions: Unaffected able to recall event...." A Behavioral Health Progress Note for Resident B, dated 7/29/2024, indicated the Social Service Director (SSD) reported that Resident B would be moving to {Name of other Facility} as he will be one of two residents on their memory care unit and hoped this decrease his aggressive behaviors. A Social Services Note-Late Entry: dated 7/30/2024 at 3:35 P.M., indicated: Resident E had no recollection of the altercation between himself & a peer on 7/28/2024. A canceled Care Plan, dated 4/12/2023, indicated Resident B had exhibited behaviors including: physical aggression towards peers and staff; yelling an cursing; wandering into rooms of peers, restlessness and difficulty sleeping. Interventions included, but were not limited to: Administer medications as ordered; Attempt to ascertain cause for aggression/wandering such as hunger- offer ice cream, need to toilet, pain- headaches			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	and administer prn medication as ordered; Attempt to guide away from source of distress; Attempt to redirect me by talking to me about cars, my family; continue follow up with psych services, transfer to behavioral health initiated on 5/12/2024, place on one on one initiated on 5/29/2024, placed on 1:1 monitoring initiated on 6/16/2024 and Transfer out to behavioral health initiated on 6/17/2024 During an interview, on 8/13/2024 at 2:40 P.M., the Director of Nursing indicated there were no new interventions added for Resident B for the altercation's with the other residents to prevent abuse recurrence and should have been. On 8/7/2024 at 10:05 A.M., the Executive Director provided the policy titled,"Abuse Policy", dated 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents...The Facility shall have processes in place to include screening, training, prevention, identification, protection...to all allegations of potential or actual abuse and neglect...." This Federal tag relates to complaint IN00434526. 3.1-27(a)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure a comprehensive person-centered plan of care was created for residents with delusions (Residents 36 & E) a resident with hallucinations (Resident 55), and for a resident	F 0656	F 656 Develop/Implement Comprehensive Care plan It is the practice of this facility to develop/implement person centered comprehensive care	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	receiving hospice care (Resident 16) for 4 of 21 residents reviewed for comprehensive care plans. Findings include: 1. The record for Resident 36 was reviewed on 8/9/2024 at 1:00 P.M. Diagnoses included, but were not limited to: psychotic disorder with delusions, depression, dementia with agitation, and anxiety. A Significant Change Minimum Data Set assessment (MDS), dated 6/20/2024, indicated the resident had received antipsychotic and antidepressant medications. Resident 36's medications included, but were not limited to: Paliperidone ER (an antipsychotic) Extended Release 24 Hour 3 mg (milligram) give 1 tablet by mouth one time a day for delusions related to psychotic disorder with delusions. The clinical record lacked a person centered care plan for delusions. During an interview, on 8/13/2024 at 9:42 A.M., the Director of Nursing indicated there should have been a person centered care plan for delusions. 2. The record for Resident E was completed on 8/8/2024 at 2:13 P.M. Diagnoses included, but were not limited to: dementia, depression and psychotic disorder. An Admission Minimum Data Set (MDS) assessment, dated 7/22/2024, indicated the resident had delusions. Resident 61'2 medications included but were not		plans for residents residing in the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Careplan for resident 36 and E were updated to reflect person centered care plans for delusions Careplan for resident 55 was updated to reflect a person centered care plan for hallucinations Careplan for resident 16 was updated to reflect a person centered care plan for hospice. **How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with diagnosis of delusions, hallucinations and hospice care have the potential to be affected by the alleged deficient practice. All residents with these diagnosis/services had care plans reviewed and updated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The policy “Care Plans, Comprehensive Person-Centered” will be reviewed by the IDT. An in-service will be held with the IDT on the policy, specifically related to person centered care plans. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	limited to: Depakote Delayed Release 250 MG (anticonvulsant) give 1 tablet by mouth one time a day for delusions.- The clinical record lacked a person centered care plan for delusions. During an interview, on 8/13/2024 at 9:24 A.M.,the Director of Nursing indicated there should have been a care plan for delusions. 3. A record review for Resident 55 was completed on 8/09/2024 at 9:17 A.M. Diagnoses included, but were not limited to malnutrition, bipolar, visual hallucinations and depression. A Quarterly Minimum Data Set assessment (MDS), dated 7/30/2024, indicated the resident had visual hallucinations and received antipsychotic medication. Resident 55's medications, included but were not limited to Aripiprazole (an antipsychotic) 10 mg give 1 tablet by mouth one time a day related to alcohol abuse with intoxication and visual hallucinations. The clinical record lacked a person centered care plan for hallucinations. During an interview, on 8/13/202 at 9:27 A.M., the Director of Nursing indicated there should have been a care plan for hallucinations and the care plan should have been person centered. During an interview, on 8/13/2024 at 9:24 A.M.,the Director of Nursing indicated there should have been a care plan for the delusions. On 8/13/2024 at 10:37 A.M., the Director of		progress notes will be reviewed during clinical morning meeting and any resident changes will be updated on the care plans. A performance improvement tool has been developed to audit that residents with delusions, hallucinations and those receiving hospice services have person centered care plans. **How the corrective actions will be monitored to ensure the deficient practice does not recur;** A performance improvement tool has been initiated that randomly audits (5) residents to ensure person centered care plans are in place. This performance improvement tool will be completed by the Director of Nursing/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **By what date the systemic changes will be made 9-13-24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	Nursing provided the policy titled, "Care Plans, Comprehensive Person-Centered", dated 9/2022, and indicated the policy was the one currently use by the facility. The policy indicated"...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The service provided or arranged by the facility, as per the comprehensive care plan, must be culturally-competent and trauma-informed....1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment... The comprehensive, person-centered care plan will...d. Incorporate interventions to address cultural needs, psychosocial needs, mitigate/reduce risk for trauma related triggers...h. Incorporate identified problem areas...10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process....4. The record for Resident 16 was reviewed on 8/8/2024 at 3:37 P.M. Diagnoses included, but were not limited to, alcohol dependence with dementia, vascular dementia, delusional disorders, anxiety, pain, and hypertension. A Quarterly Minimum Data Set (MDS), dated 6/22/2024, indicated the resident was rarely/never understood and received hospice care. Current physician orders for Resident 16 included, but were not limited to, Hydrocodone-Acetaminophen 5-325 mg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	(milligram) one tablet by mouth four times a day for pain related to other chronic pain, Ativan 1 mg (milligram) one tablet by mouth one time a day for anxiety and admit resident to Transitions Hospice for end stage/terminal diagnosis of cerebral atherosclerosis effective 9/15/2023. A current Care Plan, intiated on 5/28/2024, for Resident 16 included, but was not limited to, administration of comfort medications as ordered, allow resident to verbalize fears and concerns about the dying process, hospice aide to meet with resident per schedule, hospice chaplain to meet with resident per schedule, hospice nurse to meet with resident per schedule, hospice social worker to meet with resident per schedule, notify hospice of any change in condition and offer private room if available. On 8/9/2024, at 2:58 P.M., during an interview, the DON indicated the hospice care plan was not person-centered. On 8/13/2024 at 10:37 A.M., the Director of Nursing provided the policy titled, "Care Plans, Comprehensive Person-Centered", dated 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The service provided or arranged by the facility, as per the comprehensive care plan, must be culturally-competent and trauma-informed....1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment... The comprehensive, person-centered care plan will...d. Incorporate interventions to address cultural needs, psychosocial needs, mitigate/reduce risk for trauma related triggers...h. Incorporate identified problem areas...10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process...." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to provide a baseline care plan meeting and routine care plan meeting for 1 of 3 residents reviewed for care planning. (Resident 53) Finding includes: During an interview, on 8/7/2024 at 10:08 A.M., Resident 53 indicated the facility would not let him access his test results until he was discharged. On 8/7/2024 at 11:26 A.M., Resident 53 indicated that he had not had a baseline care plan meeting, nor any care plan meeting since admission. A record review for Resident 53 was completed on 8/9/2024 at 9:24 A.M. Diagnoses included, but were not limited to: alcohol abuse, diabetes mellitus type 2, idiopathic acute pancreatitis, cannabis use, iron deficiency anemia, and chronic kidney disease. Resident 52 was admitted to the facility on 5/1/2024.	F 0657	F 657 Care Plan Timing and Revision It is the practice of this facility to hold care plan meetings with residents/representatives after each MDS assessment, including both the comprehensive and quarterly reviews. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; A care plan reviewed was scheduled with resident 53 and conducted with the IDT on 8/21/24. **How other resident 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	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	During a review of the Electronic Medical Record (EMR) from admission to the current date of 8/7/2024 for Resident 53, no documentation could be located regarding a baseline care plan meeting, nor a routine care plan meeting. During an interview, on 8/12/2024 at 2:19 P.M., the Social Service Director (SSD) indicated most likely Resident 53 had not had a baseline care plan meeting, and had not had a meeting set up since his admission. She indicated Resident 53 was in her office daily, but the communication had not been documented. A policy was provided by the Director of Nursing, on 8/13/2024 at 10:27 A.M. The policy titled, "Care Plans, Comprehensive Person-Centered", indicated, " ...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The services provided or arranged by the facility, as per the comprehensive care plan, must be culturally-competent and trauma-informed ...1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ...4, Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan, including the right to: a. Participate in the planning process ...." 3.1-35(d) (2)(B)		be affected by the alleged deficient practice. All residents charts were reviewed to determine the date of the last resident care plan meeting. The resident/representative will be contacted to schedule a meeting for those residents that did not have a care plan meeting held after admission or last MDS assessment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The policy “Care Plans, Comprehensive Person-Centered” will be reviewed by the IDT. An in-service will be held with the IDT on the policy, specifically the timing of care plan meetings. A performance improvement tool has been developed to audit that residents/representatives have been invited to a care plan meeting after each admission or comprehensive or quarterly assessments. **How the corrective actions will be monitored to ensure the deficient practice does not recur;** A performance improvement tool has been initiated that randomly audits (5) residents to ensure care plans meeting were held after each admission or comprehensive or quarterly assessment. This performance improvement tool will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
			be completed by the Social Service Director/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **By what date the systemic changes will be made 9-13-24**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to provide activities of daily living (ADLs) regarding shower/bathing opportunities (Residentt 53 and 9) and nail, hair and shaving assistance (Resident 1) for 3 of 3 residents reviewed for ADL care. Findings include: 1.During an interview, on 8/7/2024 at 11:22 A.M., Resident 53 indicated he had only received 2 showers in the last month and a half. He indicated the certified nursing assistants (CNAs) would offer to provide showers between 11 P.M. and 3 A.M. He indicated his preference was to clean up himself as he did not like being woken up at midnight to take a shower. A record review for Resident 53 was completed, on 8/9/2024 at 9:24 A.M., Diagnoses included, but were not limited to: alcohol abuse, diabetes mellitus type 2, cannabis use, chronic kidney	F 0677	It is the practice of this facility that necessary services will be provided for resident that require assistance to maintain good grooming and personal hygiene **The corrective action taken for those residents found to be affected by the alleged deficient practice.** Resident 53 has been discharged from the facility. Resident 9 was offered a shower and care plan was updated to reflect residents preferred time and type of bathing . Resident 1 received haircut, shave and nails were trimmed and cleaned. Other residents that have the potential to be affected have been identified and corrective actions taken.	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	disease, and iron deficiency anemia. A Quarterly Minimum Data Set (MDS) assessment, dated, 8/9/2024, indicated Resident 53 was cognitively intact. An MDS assessment, dated 5/17/2024, indicated it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. He required partial/moderate assistance with bathing. A current Care Plan for Resident 53, dated 5/10/2024, indicated he had an activities of daily living (ADL) self-performance deficiency related to decreased mobility, mild intellectual deficiency, confusion related to alcohol abuse and withdraw, and incontinence. Interventions included, but were not limited to: Resident 63 required assistance as needed with bathing and showering. The Documentation Survey Report, from 5/1/2024-8/11/2024 indicated the following showers had occurred: -5/16/2024 -5/20/2024 -5/22/2024 -5/27/2024 -6/7/2024 -6/14/2024 -6/26/2024 -6/27/2024 -7/7/2024 -7/8/2024 -7/19/2024 -7/31/2024 -8/2/2024 -8/4/2024 -8/9/2024 A review of the ADL charting from		**All residents who need assistance with activities of daily living have the potential of being affected. Residents that require assistance have been identified and bathing/showering, grooming and shaving have been offered at least twice weekly**. **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include**: Licensed nurses and certified nursing assistants have been in-serviced on providing ADL care to those residents that need assistance especially bathing/showering and grooming, shaving assistance. The policy regarding provision of care has been reviewed by the IDT team. A random review of resident personal hygiene will be completed to ensure compliance. **The corrective action taken to monitor the deficient practice to ensure it will not recur:** A performance improvement tool has been initiated that randomly reviews 5 residents to ensure that bathing was completed per resident preference, including grooming/shaving. This performance improvement tool will be completed by the Director of Nursing/ Designee on (5) residents weekly for four weeks; then monthly for three months, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	7/12/2024-8/9/2024 indicated, Resident 53 had refused showers on: -7/12/2024 -7/19/2024 -8/9/2024 Refusal shower sheet form,kept by the facility, indicated Resident 53 had documented refusals of showers on 6/27/2024 and 8/1/2024. During an interview, on 8/12/2024 at 1:20 P.M., the Director of Nursing (DON) indicated upon admission the resident was to be interviewed for their preference for shower times. This included asking for day/evening shift preference (before or after lunch) and evening/night preference (before supper or after supper). She indicated there was no documentation of Resident 53's preferences from the interview available. The DON indicated she was not aware of Resident 53 had an issue with his shower being offered on third shift. She indicated the staff would ask up to 3 times for refusals, and then the refusal would be documented on a shower sheet, and the nurse tried to make a progress note. She indicated shower sheets were not kept for accepted showers. 2. During an interview, on 8/7/2024 at 1:54 P.M., Resident 9 indicated she had not received her showers on Saturdays or Tuesdays. A record review for Resident 9 was completed on 8/9/2024 at 11:19 A.M. Diagnoses included, but were not limited to: vascular dementia, cutaneous abscess of the abdominal wall, schizophrenia, and anxiety disorder. A Quarterly Minimum Data Set (MDs) assessment, dated 6/21/2024, indicated Resident 9		quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **By what date the systemic changes will be made 9-13-24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	was cognitively intact and had surgical wounds. A Discharge with Return Anticipated assessment, dated 6/17/2024, indicated Resident 9 needed bathing supervision or touch assistance. A current Care Plan, dated 8/2/2017, and revised on 3/6/2020, indicated Resident 6 required assistance with activities of daily living (ADLs) due to dementia, bipolar, schizophrenia, cervical stenosis, neuropathy, fibromyalgia, cancer with chemotherapy, knee replacement, seizures and traumatic brain injury. An intervention, dated 2/28/2018, and revised on 6/9/2024, indicated Resident 6 preferred to complete bathing with assistance as needed. The Documentation Survey Report, dated 7/1/2024-8/12/2024 indicated the following showers occurred: -7/2/2024 -7/17/2024 -7/20/2024 -7/26/2024 Refusal shower sheets, kept by the facility, indicated Resident 9 had documented refusals per the shower sheets for: -7/12/2024 -7/16/2024 -7/17/2024 -7/192024 -7/23/2024 -8/2/2024 During an interview, on 8/12/2024 at 1:23 P.M., the Director of Nursing (DON) indicated Resident 9 was prone to refusing showers. She indicated the staff asked up to 3 times for refusals, and then the refusal would be documented on a shower sheet,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	and the nurse tried to make a progress note. Shower sheets were not kept for accepted showers. The DON indicated Resident 6 had not been care planned for refusals of showers.3. During an observation, on 8/7/2024 at 10:13 A.M., Resident 1 was observed with long fingernails with a black substance underneath them, long, dirty facial hair noted thanging over his top lip and greasy hair. During an observation, on 8/8/2024 at 10:52 A.M., Resident 1 was observed with long fingernails with a black substance underneath them, long, dirty facial hair noted hanging over his top lip and greasy hair. A record review for Resident 1 was completed on 8/8/2024 at 1:40 P.M. Diagnoses included, but were not limited to: cerebral palsy, epilepsy, gastrostomy status, intellectual disabilities, diabetes mellitus type 2, protein calorie malnutrition, hyperlipidemia and restlessness. An Nursing Admission assessment, dated 6/4/2024, indicated Resident 1 was a total assist for activities of daily living, including personal hygiene, mobility, toilet use, transfers and bathing. A Quarterly Minimum Data Set (MDS) assessment was completed on 6/11/2024 and indicated Resident 1 had severely impaired cognition and was dependent on staff for all (ADL) activities of daily living, personal hygiene, mobility, toilet use, transfers and bathing. A current Care Plan, dated 6/4/2024, indicated Resident 1 had a self-care deficit and was dependent on staff for all personal hygiene needs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	During an interview, on 8/8/2024 at 2:01 P.M., RN 14 indicated Resident 1 needed his nails trimmed and cleaned, his hair needed washed and indicated Resident 1 required total staff assistance for care needs. RN 14 indicated she was unsure of his shower days and did not know when he received his last shower. During an interview, on 8/13/2024 at 1:34 P.M., the Director of Nursing indicated Resident 1 should have scheduled showers completed and staff should be trimming his nails and facial hair. On 8/13/2024 at 10:27 A.M., the Director of Nursing provided the policy titled, "Activities of Daily Living", dated 2018, and indicated the policy was the one currently used by the facility. The policy indicated"...Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's) Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...." 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, record review and interview the facility failed to implement an indiviualized activities program for 1 of 3 Residents reviewed for activities. (Resident 1) Finding includes: During an observation, on 8/7/2024 at 10:08 A.M., Resident 1 was observed in his bed, awake. The	F 0679	It is the practice of this facility to ensure that residents are provided an ongoing program to support residents choice of activities to meet the interests of and support the well being of each resident. **The corrective action taken for those residents found to be affected by the deficient**	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	television was not on and no music was playing. During an observation, on 8/7/2024 at 1:41 P.M., Resident 1 was observed in bed sleeping. The television was not on and no music was playing. During an observation, on 8/8/2024 at 10:30 A.M., Resident 1 was observed in his room, in a chair, awake. The television was not turned on and no music was playing. During an observation, on 8/9/2024 at 9:27 A.M., Resident 1 was observed in his bed, awake. The television was not on and no music was playing. During an observation, on 8/9/2024 at 11:04 A.M., the Director of Nursing entered Resident 1's room and told staff his television should be on. A record review for Resident 1 was completed on 8/9/2024 at 1:40 P.M., Diagnoses included, but were not limited to: cerebral palsy, epilepsy, gastrostomy status, intellectual disabilities, diabetes mellitus type 2, protein calorie malnutrition, hyperlipidemia and restlessness. An Admission Minimum Data Set (MDS) assessment, dated 6/8/2024, indicated it was very important for Resident 1 to watch his favorite shows, The Price is Right or Wheel of Fortune and listen to music. A current Care Plan, dated 6/4/2024 indicated the following: " ACTIVITIES: The Resident may need modifications or adaptions to promote activity participation of suitable challenge and stimulation. Resident should engage in activity programs of interest without signs of frustration or overstimulation three times a week by reevaluation date. it is very important for the		**practice include**: ·Resident 1 had the TV turned on and was provided a radio Other residents that have the potential to be affected have been identified by: All residents who participate in individualized activities have the potential of being affected by the alleged deficient practice All residents who have individualized activities have been reviewed by the activity director to ensure there is a set curriculum for residents who receive activities and the care plan updated as indicated Facility audit was conducted on all residents who wish to be involved in individualized activities with no negative outcomes **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include**: ·In-servicing occurred with the activity director on individualized activities being provided for those residents who require them ·A performance improvement tool has been developed to monitor activities are being implemented that meet the interests/needs of each resident ·Each residents Kardex was updated to reflect their preference in individualized activities ·IDT reviewed policy for activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	Resident to have books, newspapers, music and his favorite activities and provide sensory stimulating activities such as: gentle massage with scented lotions." During an interview, on 8/09/2024 at 1:52 P.M., the Activity Director indicated the facility could not keep anything in his room or he might tear it up. She indicated his television should be on so he was able to watch his favorite shows and the staff should be observing him if it causesto determine if too much stimulation for him. During an interview, on 8/13/2024 at 11:14 AM the Director of Nursing indicated he should have received the activities he enjoyed. On 8/13/2024 at 12:23 P.M., the Director of Nursing provided the policy titled, "Activity Recreation Programs", dated 3/2015, and indicated the policy was the one currently used by the facility. The policy indicated "...The facility recreation programs are designed to meet the individual needs of each resident. 5. Programming reflects the schedules, choices and the rights of residents within the facility...." 3.1-33(a)		**The corrective action taken to monitor performance to assure compliance through quality assurance is**: A performance improvement tool has been initiated that randomly audits (5) residents to ensure individualized activities are being provided and documented. This performance improvement tool will be completed by the Administrator/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **The date the systemic changes will be made: 9/13/24**	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care Based on observation, record review and interview, the facility failed to ensure a residents' urostomy drainage bag was covered for 1 of 1 resident reviewed for urostomies. (Resident 264) Finding includes: During an observation, on 8/7/2024 at 3:10 P.M.,	F 0691	It is the practice of this facility to assure that residents with urostomies/foley catheters have drainage bags covered to maintain dignity of residents. **The corrective action taken for those residents found to be affected by the deficient**	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	Resident 264's urostomy drainage bag was on the floor with no dignity bag covering it. T. During an observation, on 8/8/2024 at 10:47 A.M., the resident's urostomy drainage bag had no dignity bag covering it. The record for Resident 264 was completed on 8/9/2024 at 9:00 A.M. Diagnoses included, but were not limited to, spina bifida, depression, paraplegia, morbid obesity, obstructive sleep apnea, stoma of urinary tract, and colostomy status. An Admission Minimum Data Set (MDS) assessment, dated 8/9/2024, was only partially completed by the date of the record review. Resident 264's baseline care plan, dated 8/3/2024, included, but was not limited to, check tubing for kinks each shift/per policy, monitor and document intake and output as per facility policy, and observe for and document pain/discomfort due to catheter. During an observation, on 8/12/2024 at 2:46 P.M., Resident 264 urostomy drainage bag was not covered with a dignity bag. During an observation, on 8/13/2024, at 9:40 A.M., the resident's urostomy draining bag was not covered with a dignity bag. During an interview, on 8/13/2024 at 10:27 A.M., QMA 15 indicated the urostomy bag should have been covered by a dignity bag. During an interview, on 8/13/2024, at 11:27 A.M., the ADON indicated the urine drainage bag should have been covered by a dignity bag.		**practice include**: Resident 264 was provided with a dignity bag for urinary drainage system and bag was positioned off the floor . **Other residents that have the potential to be affected have been identified by:** All residents with urinary drainage systems have the potential to be affected by the alleged deficient practice. An audit of all residents with urinary drainage systems was completed with no other concerns identified. **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The policy “Indwelling Catheter Care and Management” was reviewed by the IDT. All direct care staff received education on 9/6/24 on the policy and practice of covering urinary drainage bags and positioning off the floor. A performance improvement tool has been developed to ensure urinary bags are kept covered and properly positioned **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that will review all residents with urinary drainage bags that they are covered and positioned properly. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	On 8/13/2024 at 1:47 P.M., the DON provided a policy titled, "Indwelling urinary catheter (Foley) care and management", dated 11/15/2019, and indicated the policy was the one currently used by the facility. The policy indicated " ...drainage tubing free from kinks and avoid dependent loops to allow free flow of urine ...keep drainage bag below level of patient's bladder to prevent backflow of urine into bladder ...because ...bag is hidden under clothing; it might also help the patient feel more comfortable ..." 3.1-47(a)(3)		performance improvement tool will be completed by the Director of Nursing/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **The date the systemic changes will be completed: 9/13/24**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure proper labeling and storage of respiratory equipment and provide necessary respiratory services according to physician orders for 3 of 5 residents reviewed for respiratory care (Resident 30, 46, and 215). Findings include: 1. During an observation on 8/7/2024, at 2:28 P.M., Resident 30 was being administered 4 liters (L) of oxygen via a nasal cannula (NC). The oxygen tubing was un-dated and without humidification. On 8/8/2024, at 10:51 A.M., Resident 30's oxygen tubing was not dated and without humidification. During an interview, on 8/8/2024, at 2:10 P.M. QMA 10 indicated the oxygen tubing should have a written date taped to the tubing indicating when the tubing had last been changed that the tubing..	F 0695	It is the practice of this facility to ensure that residents receiving oxygen and/or nebulizer treatments have supplies dated and stored appropriately. **The corrective action taken for those residents found to be affected by the deficient practice include**: Resident 30 had oxygen nasal cannula replaced and dated and care plan reviewed to include refusal of oxygen humidification. Resident 215 had nasal cannula replaced and dated and storage bag added to wheelchair. The nebulizer system was replaced and dated and storage bags added to the bedside table. Resident 46 had nasal cannula replaced and dated and storage	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	QMA 10 indicated the resident refused humidification as the humidity bothered the resident. On 8/9/2024, at 2:45 P.M., during an interview, the DON indicated the oxygen tubing should have been dated. A record review for Resident 30 was completed on 8/9/2024 at 9:00 A.M. Diagnoses included but were not limited to chronic obstructive pulmonary disease, Type 2 diabetes mellitus, morbid obesity, heart failure, chronic respiratory failure, hypertension, history of pulmonary embolism, and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 7/26/2024, indicated the resident was cogntively intact and utilized continuous oxygen via a nasal cannula. The current physician orders for Resident 30 included, but were not limited to: change oxygen tubing and humidification bottle, clean oxygen filter, inspect easy foam wraps and replace if soiled or missing at bedtime every Sunday and as needed, and oxygen at 4 L (liters)/minutes per nasal cannula (NC) every shift for shortness of breath and check oxygen saturation every shift to keep saturation above 90 percent. A current Care Plan, initiated 3/15/2024, indicated the resident had oxygen therapy related to shortness of breath due to chronic obstructive pulmonary disease (COPD) and respiratory failure. The Care Plan indicated to change the oxygen tubing as ordered.2. During an observation, on 8/7/2024 at 10:34 A.M., Resident 215's handheld aerosol nebulizer was observed lying in the top drawer of the bedside table, and her portable		bag added to wheelchair. **Other residents that have the potential to be affected have been identified by:** All residents receiving oxygen and/or nebulizer treatments have the potential to be effected by the alleged deficient practice. An audit was completed to ensure that oxygen cannulas and nebulizer systems were dated and storage bags were present. **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The policy “Departmental (Respiratory Therapy)-Prevention in Infection” was reviewed by the IDT. All direct care staff received education on the policy and the practice of dating and storage of respiratory equipment on 9/6/24. A performance improvement tool has been developed to ensure respiratory equipment is dated and stored properly. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that will review all residents with oxygen or nebulizer treatments to ensure tubing/nebulizer system is dated and stored in bags when not in use. This performance improvement tool will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	oxygen nasal cannula was draped over her wheelchair, and was not dated. On 8/8/2024 at 10:05 A.M., Resident 215's handheld aerosol nebulizer was lying on top of the bedside table. A record review for Resident 215 was completed, on 8/12/2024 at 10:17 A.M. Diagnoses included, but were not limited to: systemic lupus, chronic respiratory failure, chronic obstructive pulmonary diseases (COPD), and heart failure. An Admission Minimum Data Set (MDS) assessment, dated 8/1/2024, indicated Resident 215 received oxygen therapy, and had shortness of breath or trouble breathing while lying flat. A Physician's Order, dated 7/26/2024, indicated to give one vial of ipratropium-albuterol 0.5-2.5 milligrams three times daily via the nebulizer. A Physician's Order, dated 8/3/2024, indicated the resident was to receive oxygen at 4 liters per minute via nasal cannula continuously. A current Care Plan, dated 7/29/2024, indicated Resident 215 had oxygen therapy related to respiratory failure and COPD. Interventions included oxygen per nasal cannula at 4 liters continuously. During an observation, on 8/12/2024 at 10:36 A.M., the handheld aerosol nebulizer was lying in the top drawer of the bedside table, and the portable oxygen nasal cannula was draped over the wheelchair and not dated. During an interview, on 8/12/2024 at 1:18 P.M., the Director of Nursing (DON) indicated respiratory		completed by the Director of Nursing/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **The date the systemic changes will be completed: 9/13/24.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	equipment, including nebulizer equipment, should be stored in respiratory bags and were to be dated. 3. During an observation, on 8/7/2024 at 10:49 A.M., Resident 46's portable oxygen nasal cannula was draped over the wheelchair. On 8/9/2024 at 10:51 A.M., the portable oxygen nasal cannula was not dated. A record review for Resident 46 was completed on 8/9/2024 at 10:21 A.M. Diagnoses included, but were not limited to: emphysema, COPD, and dyspnea. A Physician's Order, dated 7/16/2024, indicated oxygen at 2 liters per minute per nasal cannula as needed for shortness of breath. A current Care Plan, dated 5/17/2024, indicated Resident 46 had emphysema and COPD. An intervention, dated 7/17/2024, indicated oxygen at 2 liters via nasal cannula as needed was to be provided. On 8/12/2024 at 11:40 A.M., the portable oxygen nasal cannula was not dated. During an interview, on 8/12/2024 at 1:18 P.M., the Director of Nursing indicated respiratory equipment should be stored in respiratory bags and should be dated. A policy was provided by the Director of Nursing, on 8/13/2024 at 10:27 A.M. The policy titled, "Departmental [Respiratory Therapy]-Prevention in Infection", indicated, " ...The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	equipment, including ventilators, among residents and staff ...Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol ...7. Store the circuit in plastic bag, marked with the fate and resident's name, between uses ...Infection Control Considerations Related to Oxygen administration ...7. Change the oxygen cannulae and tubing every seven [7] days, or as needed ...8. Keep the oxygen cannulae and tubing used PRN [as needed] in a plastic bag when not in use ...." 3.1-47(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure narcotics were counted and documented every shift for 1 of 4 narcotic count log books reviewed. (Freedom cart 1) Finding includes: A Medication Storage observation of the Freedom hall medication cart was completed, on 8/9/2024 at 10:40 A.M., with QMA 2. The narcotic log book lacked signatures on 8/3/2024 to show a narcotic count was completed. During an interview, on 8/9/2024 at 10:46 A.M.,QMA 2 indicated the narcotic log sheets should have been signed every shift. On 8/13/2024 at 10:39 A.M., the Director of Nursing provided the policy titled, "Controlled Substance",undated, and indicated the policy was the one currently used by the facility. The policy indicated"...9. Nursing staff must count controlled	F 0755	It is the practice of this facility that an account of all controlled drugs is maintained and periodically reconciled. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were found to have been affected by the alleged deficient practice. **How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents who are administered narcotics have the potential of being affected by the	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	medications at the end of each shift. The nurse coming on duty and thru nurse going off duty must make the count together...." 3.1-25(e)(2) 3.1-25(e)(3)		deficient practice. The narcotic count sheets on all medications carts were audited for missing signatures and will be corrected if indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The policy “Controlled Substance” will be reviewed by the IDT. An in-service will be held with the licensed nursing staff and QMA’s on the policy and necessity of signing each shift that all medications have been accounted for. A performance improvement tool has been developed to audit that narcotic sheets have been signed between the off going and oncoming nurse/QMA each shift. **How the corrective actions will be monitored to ensure the deficient practice does not recur**; A performance improvement tool has been initiated that randomly audits (5) days on all medication carts to ensure narcotic count signatures are present between the off going and oncoming nurse/QMA each shift. This performance improvement tool will be completed by the Director of Nursing/Designee weekly for four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
			weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **By what date the systemic changes will be made; 9/13/24**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately, had resident labels, and medication carts were free of loose pills for 2 of 2 medication carts observed.(Freedom medication carts 1 and 2) Findings include: 1. During a medication storage observation, on 8/9/2024 at 9:22 A.M., with QMA 2 on Freedom hall med cart 1, the following was observed: - 1 box of Xalanta eye drops was stored with injectable medications. - A bottle of Colace (stool softener) pills had no resident identifier/label. - An opened bottle of Antacid tablets had no resident identifier/label. During an interview, on 8/9/2024 at 10:46 A.M., QMA 2 indicated the medications should have been labeled, and the eye drops should have been separated from the injectable medications.	F 0761	It is the practice of this facility to ensure that drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and expiration dates when applicable and are stored appropriately. **The corrective action taken for those residents found to be affected by the deficient practice include:** Eye drops were moved to the appropriate storage compartment. Bottle of Colace was labeled with resident identifying information and physician name Loose pills were removed from bottom of cart drawer. Bottle of Derma Klenze , Ipratropium ampules and antacid tables were removed from	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	2. During a medication storage observation, on 8/9/2024 at 10:50 A.M., with LPN 3 on Freedom hall medication cart 2, the following was observed: -3 loose pills in 2 drawers. - A bottle of Derma Klenze (wound cleanser) stored with liquid medications. - Two (2) opened and undated bottles of Mira lax granules (laxative). - An opened package of Ipratropium Bromide ampules (aerosol medication) had no resident identifiers. During an interview, on 8/9/2024 at 11:06 A.M., LPN 3 indicated there should be no loose pills in the medication cart, the medications should have been labeled and the wound cleanser should not be stored with medications. On 8/13/2024 at 10:39 P.M., the Director of Nursing provided the policy titled, "Storage of Medications and Biological's", dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated"...8. Potential harmful substances are clearly identified and stored in a locked area separately form the medication(s).a. Potential harmful substances may include, but are not limited to, urine test, reagent tablets, household poisons, cleaning supplies, and disinfectants...." On 8/13/2024 at 10:39 A.M., the Director of Nursing provided the policy titled "Medication Labels", dated 5/20/2020, and indicated the policy was the one currently use by the facility. The policy indicated"...5. Nonprescription medications not labeled by the pharmacy are kept in the manufacture's original container and identified with the resident's name... 10...The manufacturer or pharmacy label should include the following: a. Medication Name. b. Medication strength. c.		medication cart Bottles of undated Miralax were removed and reordered from pharmacy **Other residents that have the potential to be affected have been identified by:** All residents that receive medication have the potential to be affected by the deficient practice. All carts were cleaned and organized according to current standards of practice, ensuring that all medications were properly labeled and dated if opened. **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include**: The policy “Storage of Medications and Biologicals” was reviewed by the IDT. All staff that pass medications received education on the policy on 9/6/24. Cleaning and organizing of the medication carts has been added to the cleaning schedule to be completed at least weekly. A performance improvement tool has been developed to monitor that medication are stored, labeled and dated correctly and the medication cart is clean . **The corrective action taken to monitor performance to assure compliance through quality assurance is**: A Performance Improvement Tool has been initiated to review all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	Quantity. d. Accessory instructions. e. Lot number. f. Expiration date...." 3.1-25(j)		medication carts to ensure that medications are stored separately, labeled appropriately, drawers are free of loose pills, opened bottles are dated and open packages of nebulizer ampules are identified appropriately. This performance improvement tool will be completed by the Director of Nursing/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. **The date the systemic changes will be completed: 9/13/24**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to undated and unlabeled foods and drinks in 1 of 1 kitchens (Main kitchen). This issue had the potential to affect 69 of 69 residents who resided in the facility and received food from the kitchen. Findings include: On 8/7/2024, at 9:41 A.M., during an initial tour of the kitchen with the Dietary Manager, the following items were observed: -: in the double-door freezer there were 2 opened	F 0812	It is the practice of this facility to ensure that food is stored in accordance with professional standards of practice for food service safety. **The corrective action taken for those residents found to be affected by the deficient practice include**: All undated, unlabeled, expired and improperly stored food items were disposed of. **Other residents that have the potential to be affected have**	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	bags of frozen meat patties unlabeled and undated - in the double-door cooler there was a tray of beverages already poured, unlabeled and only one cup bearing the date of 8/8/2024 - the dry pantry contained multiple bread products without labels or dates that included the following: 5 hot dog bun bags, 3 hamburger bag buns and 5 English muffin bags - in the walk-in fridge there were two pitchers of juice without dates or labels. During an interview, on 8/7/2024 at 9:41 A.M., the Dietary Manager indicated all food and beverages should have labels with the name of the item and dates. On 8/13/2024, at 9:53 A.M., the Executive Director provided the policy titled, "Food Storage," dated 3/26/2020, and indicated the policy was the one currently used by the facility. The policy indicated" ... All food will be dated at time of receipt and be inventoried using the first in first out method ...Un-served leftovers shall be labeled, dated and stored for a period not to exceed three (3) days. ..." 3.1-21(i)(3)		**been identified by:** All residents who consume food from the dietary department have the potential to be affected by the alleged deficient practices. An audit was completed to ensure that all food items were not expired, were labeled with dates and stored in proper containers. **The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include**: The policy, “General Food Preparation and Handling” was reviewed by the IDT. An in-service was held with all dietary staff to educate on the policy. A Performance Improvement Tool has been developed to ensure food items are stored properly with labels and dates. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that randomly audits 5 shifts to ensure that food items are labeled, dated, not expired and securely stored. The Food Service Director, or designee, will complete this tool for 5 shifts weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected and additional training will be initiated. The Quality Assurance Committee will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
			the tools at the scheduled meetings at least quarterly. **The date the systemic changes will be completed: 9-13-24**	