STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155710	A. BUILDING 00 B. WING	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHASE CENTER	2 CHASE PARK LOGANSPORT, IN 46947

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 28, 29, 30, 31 and November 1 and 4, 2024 Facility number: 000021 Provider number: 155710 AIM number: 100275270 Census Bed Type: SNF/NF: 68 SNF: 3 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 54 Other: 15 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 8, 2024.	F 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during this inspection. I would like to formally request your consideration for granting this facility paper compliance. Chase Center submits this plan of correction (POC) in accordance with specific regulatory requirements. The submission of the POC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact myself, Lacey Schnurpel, Administrator at 574-753-4137.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for 1 of 1 resident reviewed for MDS accuracy. (Resident 28) Finding includes:	F 0641	1 The resident diagnosis list was corrected for resident #28. All relevant MDS's were corrected for this resident. (See attached exhibit A) 2 A facility-wide audit was conducted, and no additional	11/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lacey R. Schnurpel	Administrator	11/22/2024

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	The clinical record for Resident 28 was reviewed on 10/30/24 at 3:28 p.m. The diagnoses included, but were not limited to bipolar disorder, vascular dementia, intermittent explosive disorder, conduct disorder, and visual hallucinations. An annual MDS assessment, dated 12/14/23, indicated the resident had a diagnosis of bipolar disorder. A quarterly MDS assessment, dated 5/30/24, indicated the resident had a diagnosis of bipolar disorder. A quarterly MDS assessment, dated 8/20/24, indicated the resident had a diagnosis of bipolar disorder. The psychiatry nurse practitioner notes, dated 9/5/24 and 10/3/24, indicated the resident had a diagnosis of bipolar disorder. The assessment and plan indicated no changes to the current plan of care. A psychiatry nurse practitioner late entry note, dated 10/31/24, indicated incorrect documentation was struck out of the resident's Electronic Health Record (EHR) notes for 9/5/24 and 10/3/24. During an interview, on 10/31/24 at 9:16 a.m., the Administrator indicated Resident 28 did not have a diagnosis of bipolar disorder. The diagnosis was added in error to the MDS assessment and to the resident's EHR. During an interview, on 11/4/24 at 3:30 p.m., the MDS Coordinator indicated she coded the resident's MDS assessment incorrectly. The bipolar diagnosis was added to the resident's record in error. The MDS Coordinator could not		residents were identified. (See attached exhibit B) 3 The Interdisciplinary team met and reviewed the policy. The Interdisciplinary team will review any new diagnosis of bipolar obtained at the morning clinical meeting to ensure the appropriate level 2 was completed, Diagnosis was added to diagnosis list and MDS's are appropriately coded. (see attached Exhibit C) 4 An audit will be completed weekly x6 months and results will be reviewed at the monthly QAPI meeting. In the event that any concerns are identified from the audit tool; the issue will be immediately corrected and additional training will be initiated. (see attached exhibit D)	

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	find any documentation Resident 28 had a diagnosis of bipolar disorder. A current policy, titled "MDS Supportive Documentation Policy," dated as revised 10/10/23 and received from the Administrator on 11/4/24 at 3:57 p.m., indicated "...To accurately record the needs of our residents through MDS assessments, as required by federal regulations...Supportive Documentation in the medical record must be dated during the assessment reference period to support the MDS Responses...The Assessment Reference Date (ARD) is the last date for collecting MDS data...The Social Services Director will be responsible for the following CAA's and Care Plans: a. Delirium, b. Cognitive Loss/Dementia, c. Psychosocial Well Being, d. Mood State, e. Behaviors, f. Return to the Community/Referral...." 3.1-31(d)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed for a resident identified as a high risk for elopement for 1 of 6 residents reviewed for accidents. (Resident 4) Finding includes: The clinical record for Resident 4 was reviewed on 10/29/24 at 4:10 p.m. The diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies (a type of dementia), anxiety, dementia without behavioral, psychotic or mood disturbance, and visual hallucinations.	F 0656	1 The care plan for resident #4 was updated 11/6/24 to include an elopement careplan. (see Exhibit E) 2 A facility-wide audit was completed to identify all moderate to high risk residents for elopement and to ensure a careplan was in place. (see Exhibit F) 3 The Interdisciplinary team met and reviewed the policy. The Interdisciplinary team will review elopement assessments indicating residents are at	11/20/2024

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	A wander risk evaluation, dated 10/8/24 at 4:13 p.m., indicated the resident had forgetfulness and/or a short attention span, had diagnoses of Alzheimer's and dementia with psychosis, was taking antipsychotics, and had a history of wandering. Her score was 11 which indicated she was at high risk for elopement. There was no comprehensive person-centered care plan in place for high-risk elopement. During an interview, on 11/4/24 at 4:00 p.m., LPN 5 indicated a care plan should have been developed. A current policy, titled "Elopement," with a revision date of 8/10/22 and received from the Administrator on 11/4/24 at 3:30 p.m., indicated "...a care plan will be developed with appropriate interventions implemented to provide for the resident's safety...an elopement binder will be kept and maintained on each unit and the front office...." 3.1-35(a) 3.1-35(d)(1)		moderate to high risk for elopement and to ensure a careplan is in place at the morning clinical meeting. An in-service was completed on 11/20/24 (see Exhibit G) 4 An audit will be performed weekly x3 months and then monthly x6 months and the results will be reviewed at our monthly QAPI meeting. In the event that any concerns are identified the issue will be immediately corrected and additional training will be initiated. (see Exhibit H)	
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 medication carts were free of loose pills and to ensure staff labeled eye drops with an opened date in 2 of 3 medication carts reviewed for medication storage. (200-unit and 300-unit) Findings include: 1. During a medication cart observation with	F 0761	1 The eye drops for resident #4, 56 and 61 were all destroyed and re-ordered from pharmacy. The 200 hall medication cart was cleaned to ensure no loose pills were in the medication drawers. (see Exhibit I) 2 A facility-wide audit was performed 11/15/24 to include all of the medication and treatment	11/22/2024

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	Registered Nurse (RN) 2, on 10/30/24 at 11:34 a.m., the 200-hall medication cart was observed to have the following: a. The bottom of the second drawer had one and a half loose white pills. b. The bottom of the third drawer had one loose white pill. During an interview, on 10/30/24 at 11:41 a.m., RN 2 indicated the loose pills should be destroyed when found in the bottom of the medication cart. During an interview, on 10/30/24 at 11:44 a.m., LPN 3 indicated when pills were found in the bottom of the carts, they should be removed and put in the container located in the medication room. During an interview, on 10/30/24 at 12:30 p.m., the Director of Nursing indicated loose pills should not be in the bottom of the medication cart. There should be no loose pills in the cart.2. During an observation of the medication cart on the 300-unit, on 10/30/24 at 11:09 a.m., the eye drops for Residents 4, 56 and 61 had no open dates on the outside container or the bottle containing the eye drops. a. The clinical record for Resident 4 was reviewed on 10/29/24 at 4:10 p.m. The diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies (a type of dementia), diabetic kidney disease, and long-term use of insulin. A physician's order, dated 10/3/24, indicated to instill Systane ophthalmic solution (for dry eyes) into both eyes. b. The clinical record for Resident 56 was reviewed on 10/29/24 at 4:27 p.m. The diagnoses included, but were not limited to, hypotension		carts with no further concerns identified. (see Exhibit J) 3 The Interdisciplinary team met and reviewed the policy. Medication carts are cleaned daily. An in-service was completed 11/22/24. (see Exhibit K) 4 An audit will be performed weekly x3 months and then monthly x3 months and the results will be reviewed at our monthly QAPI meeting. In the event that any concerns are identified the issue will be immediately corrected and additional training will be initiated.	

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	(low blood pressure), cachexia (weakness or wasting of the body), anorexia, Alzheimer's disease, and dementia without behavioral psychotic or mood disturbance. A physician's order, dated 8/22/24, indicated to instill Latanoprost (used for glaucoma) in both eyes at bedtime. c. The clinical record for Resident 61 was reviewed on 10/30/24 at 11:30 a.m. The diagnoses included, but were not limited to, generalized anxiety disorder, nutritional anemia, essential hypertension, cachexia, and obsessive-compulsive disorder. A physician's order, dated 10/1/24, indicated to instill Atropine sulfate ophthalmic solution every 2 hours as needed. During an interview, on 11/10/24 at 11:10 a.m., RN 4 indicated the eye drops would need to be reordered due to not having an open date. The manufacturers guidelines for Systane eye drops indicated to dispose of the drops 1 month after opening. The manufacturers guidelines for atropine sulfate indicated to dispose of the drops 28 days after opening. The manufacturers guidelines for Latanoprost indicated to dispose of the eye drops 6 weeks after opening. 3.1-25(j) 3.1-25(o)			