STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00445328 and IN00446197. Complaint IN00445328 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00446197 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: November 12 and 13 2024. Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 3 Medicaid: 46 Other: 27 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/14/24.	F 0000	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 December 5th 2024, for the complaint survey completed November13th, 2024. Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
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 ensure dependent	F 0677	F677 [D] ADL Care Provided for Dependent Residents	12/05/2024

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

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	residents received timely assistance with ADL's (activities of daily living) related to incontinence care for 2 of 4 residents reviewed for ADL's. (Residents C and F) Findings include: 1. On 11/12/24 at 5:38 a.m., Resident C was observed lying in bed asleep. The room had a strong urine odor that could be smelled from the doorway. CNA 1 checked on the resident and asked if care could be provided. When CNA 1 pulled the sheet up from the resident's body, there was stool and urine that had leaked onto the bed sheet. The resident's brief was soiled through with urine and stool. During an interview at the time, CNA 1 indicated the resident was not soiled when she came in at 11:00 p.m. CNA 1 had not checked the resident for incontinence since 11:00 p.m. on 11/11/24. The Record for Resident C was reviewed on 11/12/24 at 12:33 p.m. Diagnosis included, but were not limited to, Alzheimer's, depression, anxiety, anemia, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/24, indicated the resident was moderately impaired for daily decision making. The resident had impairment on both sides of the lower extremities. Toileting hygiene and personal hygiene required substantial/maximum assistance and the resident was always incontinent of bowel and urine. A Care Plan, dated 10/17/24, indicated the resident was incontinent of urine. Interventions were to identify incontinence patterns, establish a toileting plan, provide incontinence care as		It is the practice of this facility that we ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Resident C and Resident F had ADL care provided immediately *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;* ·Facility audit was conducted on all dependent residents to assure ADL care was being provided with no negative outcomes. ·All residents who are dependent on ADL care have the potential to be affected by the deficient practice. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·In-servicing occurred with nursing staff to assure rounding is occurring minimally every two hours and ADL care is being	

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	needed, and provide preventative skin care with each incontinent episode. A Care Plan, dated 10/17/24, indicated the resident was incontinent of bowel. Interventions were to identify incontinence patterns, establish a toileting plan, and provide preventative skin care with each incontinent episode. A Care Plan, dated 10/17/24, indicated the resident had an ADL self-care performance deficit related to general weakness, Alzheimer's, and impaired cognition. Interventions indicated the resident required 1-2 staff members for toilet use. During an interview on 11/12/24 at 1:45 p.m., the Administrator indicated Resident C should not have been soiled, and should have been changed and repositioned every 2 hours. 2. On 11/12/24 at 5:50 a.m. and 6:39 a.m., Resident F was observed awake lying in bed. The resident indicated the brief they were wearing was soaked. The resident pulled the covers over and showed the soiled brief. During an interview at the time, Resident F indicated the brief was last changed the previous day on 11/11/24 at 3:00 p.m. The record for Resident F was reviewed on 11/13/24 at 9:55 a.m. Diagnosis included, but were not limited to, respiratory failure, oxygen dependence, weakness and difficulty walking. The Admission Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact for daily decision making. The resident was occasionally incontinent of		performed accordingly ·A performance improvement tool has been developed to monitor ADL care for dependent residents ·IDT reviewed policy for ADL care *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 ADL care is being provided and documented. This Quality Assurance Audit Tool will be completed by the DON/ Designee weekly for three 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:* 12/5/24	

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	urine and always incontinent of bowel. Toileting required substantial/maximum assistance and the resident was dependent with lower body dressing. A Care Plan, dated 10/11/24, indicated Resident F was incontinent of bowel. Interventions were to provide peri care after each incontinent episode and to provide peri skin care. A Care Plan, dated 10/11/24, indicated the resident had an ADL self care performance deficit related to impaired mobility. Interventions indicated the resident was totally dependent on staff for toilet use and the resident required 2 staff participation for bed mobility. During an interview on 11/12/24 at 1:48 p.m., the Administrator indicated Resident F should not have been soiled, and should have been changed every 2 hours. This citation relates to Complaint IN00445328. 3.1-38(a)(2)(C)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (CNA 3) when providing care to a resident (Resident E) who was in Enhanced Barrier Precautions (EBP) and failed to ensure hand hygiene was completed by a staff member (CNA 2) after the care had been completed, for one random observation for infection control. Finding includes:	F 0880	F880 Infection Prevention & Control It is the practice of this facility to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by ensuring infection control guidelines are in place and implemented. *What corrective action(s) will be*	12/05/2024

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	During an observation on 11/12/24 from 5:37 a.m. through 5:59 a.m., the following was observed: At 5:37 a.m., Resident E was lying in bed. She indicated she had been incontinent of a bowel movement. A urinary catheter drainage bag was observed positioned on the the side of the bed. A sign posted above the bed indicated Enhanced Barrier Precautions were to be used during care. At 5:40 a.m., CNA 3 entered the room and indicated she would need to have another staff member assist her with the incontinence care. CNA 3 donned gloves, retrieved a plastic measuring container from the bathroom, and started to empty out the urinary catheter drainage bag. CNA 3 was stopped prior to starting the task. She indicated the resident required EBP, then continued to empty the urine into the measuring container without the the correct PPE applied (gown). She indicated there was 900 milliliters of urine drained from the bag and emptied the measuring container in the toilet. CNA 3 then donned a gown over her uniform. At 5:55 a.m., CNA 2 entered the room and asked CNA 3 why the gown was worn. CNA 3 indicated the resident was on EBP due to the urinary catheter. CNA 2 indicated she was unaware the resident required EBP. At 5:59 a.m., incontinent care was completed. Resident E requested fresh water for her tumbler. CNA 2 removed one glove, pulled the trash bag out of the trash can and tied the bag, then picked up the tumbler and walked to the door. She then removed the gown and the other glove and rolled it in a wad, and exited the room, while holding the tumbler and the closed trash bag. She then obtained a new trash bag located on the side of		*accomplished for those residents found to have been affected by the deficient practice:* C.N.A 3 and C.N.A 2 were in-serviced on handwashing and EBP isolation protocols *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:* All residents who are cared for with isolations have the potential to be affected by the alleged deficient practice. ·Facility audit was conducted on all residents in EBP. precautions were being followed with no negative outcomes . *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.* IDT reviewed policy on EBP and handwashing, Nursing staff were in-service on EBP and Handwashing. A performance improvement tool has been developed to monitor proper EBP procedure is being followed and proper hand hygiene is being performed *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 five (5) days to monitor EBL procedure is being followed and	

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	the Medication Cart, sitting outside the room in the hall, and placed the gown and glove in the bag and tied the bag up and started to walk down the hallway. CNA 2 was stopped. She indicated the hand gel in the hallway was, "old" and she would wash her hands. She delivered the trash bags to the soiled utility room, walked out of the room then entered the pantry with the tumbler and washed her hands in the pantry's sink. Resident E's record was reviewed on 11/12/24 at 7:47 a.m. The diagnoses included, but were not limited to, cystitis and lung cancer. A Quarterly Minimum Data Set assessment, dated 8/27/24, indicated an intact cognitive status, was dependent for toileting and bed mobility, and had an indwelling catheter. A Care Plan, dated 4/4/24, indicated a suprapubic urinary catheter was present and EBP was required. The interventions included, the EBP would be used and appropriate hand washing procedures would be completed after care was completed. A Physician's Order, dated 8/27/24, indicated EBP was to be used due to the suprapubic catheter. A facility EBP policy, dated 8/2022 and received as current from the Director of Nursing (DON) on 11/13/24 at 8 a.m., indicated a gown and gloves were to be used during high contact resident care activities. Face protection may be used if there was a risk of splashing or spray. The examples of high contact activities included hygiene, brief change, and device care (urinary catheter). The communication for EBP included signage would be used.		proper hand hygiene is being performed. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three 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: 12/5/24	

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	A facility hand hygiene policy, dated 11/28/2016 and received from the DON as current, indicated hand hygiene was the final step after removing and disposing of personal protective equipment. 3.1-18(b)			