STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155759	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

(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 a State Residential Licensure Survey. Survey dates: August 7, 8, 9, 12, and 13, 2024 Facility number: 011187 Provider number: 155759 AIM number: 200838150 Census bed type: SNF: 14 SNF/NF: 36 Residential: 25 Total: 75 Census payor type: Medicare: 14 Medicaid: 31 Other: 5 Total: 50 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 15, 2024.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Recertification Survey. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 30th,2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy R Nelson	Executive Director	08/22/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, interview, and record review, the facility failed to ensure Resident 9 had fresh ice water available at the bedside for 1 of 1 resident reviewed for hydration. Findings include: The clinical record for Resident 9 was reviewed on 8/9/2024 at 12:40 p.m. The medical diagnosis included heart failure. The Minimum Data Set assessment, dated 7/15/2024, indicated Resident 9 was cognitively impaired but was not dehydrated. A diuretic care plan, dated 10/30/2023, indicated Resident 9 was at risk for medication complications related to the use of diuretics. An intervention, dated 10/30/2023, indicated to encourage fluids throughout the day if not contraindicated. During an interview and observation, on 8/7/2024 at 11:32 a.m., Resident 9 indicated ice water was rarely passed to the resident's room. The cup of water in the room was room temperature and had no ice in it. During an interview and observation, on 8/9/2024 at 1:30 p.m., Resident 9 indicated the staff rarely passed ice water to the resident's room. There were three containers of water in the room. First was a Styrofoam cup, dated 8/8/2024, which Resident 9 stated was "hot and stale", the second was a clear cup with no date which Resident 9 stated was "warm and from breakfast yesterday", and the third was metal container personal glass which had no water in it. Resident 9 indicated outside of meals and medication pass, no one had	F 0558	F558 1. Resident #9 was affected. No adverse effects noted. Fresh ice water given to resident. 2. All residents have the potential to be affected. Nursing staff will be educated on passing ice water every shift. 3. As a measure of ongoing compliance, the DHS or designee will perform audit to ensure ice water is passed to residents, as appropriate. Audits will be conducted as follows: 5 residents once a week x4 weeks, then once every other week x2 months, then monthly x3 months. 4. For quality assurance, the ED will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. 5. Compliance Date: 8/30/24	08/30/2024

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	given any additional fluids, and no staff had refreshed the water in the room since yesterday, 8/8/2024. An interview with CNA 1, on 8/9/2024 at 1:35 p.m., indicated staff were to pass ice water every shift, but ice water had not been passed yet because CNA 1 did not have time to complete the task yet. An interview with the Director of Health Services, on 8/12/2024 at 2:05 p.m., indicated any staff member can pass ice water, but it was primarily the responsibility of the direct care staff to pass ice at least every shift unless medically contraindicated. An interview with the Regional Nurse Consultant, on 8/12/2024 at 2:40 p.m., indicated that the facility did not have a policy for passing ice water to residents. 3.1-3(v)(1)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may			

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	have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those			

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	grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less			

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	than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to follow their grievance policy regarding a resident's missing clothing for 1 of 1 resident reviewed for personal property. (Resident 39) Findings include: The clinical record for Resident 39 was reviewed on 8/8/24 at 11:40 a.m. The diagnoses included, but were not limited to, anxiety. She was admitted to the facility on 6/11/24. The 6/17/24 Admission MDS (Minimum Data Set) assessment indicated Resident 39 was cognitively intact. An interview was conducted with Resident 39 on 8/8/24 at 11:20 a.m. She indicated she was missing two shirts and a pair of jean pedal pushers. The two tops went missing a couple weeks after she was admitted to the facility, and the jeans went missing about two weeks ago. She informed staff, including some of the CNAs (Certified Nursing Assistants) and laundry staff, of the missing items, and they informed her they'd "keep an eye out." An interview was conducted with the ED (Executive Director) on 8/12/24 at 1:50 p.m. She indicated when a resident voiced they were missing clothing, they typically took the resident into the laundry room to identify the clothing and/or contacted laundry staff to look for the clothing. If the clothing was unable to be located, the facility replaced it. They also filled out a resident concern form and documented follow-up with the resident. She did not recall a concern for	F 0585	F585 1 Resident #39 clothing was located and returned. 2 All residents have the potential to be affected. Facility staff will be educated on the Facility Grievance policy. 3 As a measure of ongoing compliance, ED/Designee to audit residents with missing clothing to ensure the grievance process is completed per policy. Auditing will consist of 5 residents once a week for 4 weeks, every other week x 2 months and then monthly x 3 months. 4 For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. 5 Compliance Date: 8/30/24	08/30/2024

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	Resident 39 regarding missing clothing. On 8/12/24 at 10:30 a.m., the ED provided the Resident Concerns Log for the past month. There were no concerns regarding missing clothing for Resident 39. An interview was conducted with ESA (Environmental Services Assistant) 2 in the laundry room of the facility on 8/12/24 at 1:57 p.m. She indicated Resident 39 informed her and some of the CNAs of her missing jean pedal pushers and two shirts a few weeks ago. ESA 2 looked for the items but was unable to locate them. ESA 2 did not fill out a resident concern form, as many residents complained of missing items. She informed staff they could bring Resident 39 into the laundry room to look for her items, but no one ever did. The Resident Concern Process policy was provided by the ED on 8/12/24 at 2:04 p.m. It read, "Purpose: To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service. Procedures: ...5. Enter the concern using the desktop icon labeled 'Resident Concern Form.' All concerns should be entered electronically, however Environmental and Dining departments may use a paper Resident Concern form, submitting to their supervisor who will enter....6. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution. 7. Follow up from the department leader will occur within 24-48 [sic] with resolution entered in KeyStats. 8. The Executive Director will review and manage the follow up of the concerns. 9. The department leader will investigate and discuss the concerns with the team and will implement, or educate to prevent			

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	further concerns. 10. The department leader will document the resolution on the concerns form using an addendum when needed and will follow up with the person reporting the concern to explain the resolution." 3.1-7(b)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review the facility failed to implement a sling for a resident with impaired range of motion (ROM) for 1 of 1 resident reviewed for ROM (Resident 16). Findings include: During an observation and interview on 8/07/24 at 1:43 p.m., Resident 16 was sitting in a wheelchair	F 0688	F688 1. Resident #16 had no adverse effects noted. Resident screened by therapy for any adaptive equipment needs. 2. Residents with limited ROM have the potential to be affected. Nursing staff to be educated on monitoring for decreases in ROM	08/30/2024

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	outside. The resident's right hand was curved inward. Resident 16 indicated he was unable to move his right arm and right hand. The resident took his left hand and picked up his right arm and hand and they were flaccid (hanging loosely/limp). The resident indicated he had a sling to wear, and it was in his room. During an observation and interview on 8/08/24 at 10:31 a.m., Resident 16 was sitting in a wheelchair outside with no sling in place. The resident's right arm and hand was laying on his lap. During an observation on 8/09/24 at 10:57 a.m., Resident 16 was sitting in a wheelchair outside with no sling in place. The resident's right arm and hand was laying on his lap. During an observation on 8/12/24 at 10:20 a.m., Resident 16 was sitting in a wheelchair outside with no sling in place. The resident's right arm and hand was laying on his lap. During an observation and interview on 8/12/24 at 1:53 p.m., Resident 16 was sitting outside with a sling in place to the right arm and hand. The resident indicated the sling was in a drawer in his room and the staff helped him put it on. He indicated his right arm and hand felt better supported in the sling. During an interview with the Director of Health Services (DHS) on 8/12/24 at 1:58 p.m., indicated she found Resident 16's sling in a drawer in his bedroom. The DHS indicated she talked with the resident, and he wanted to wear the sling for comfort. The clinical record for Resident 16 was reviewed on 8/9/24 at 11:00 a.m. The diagnoses included,		and mobility. 3. As a measure of ongoing compliance, the DHS or designee, will audit 5 residents for limited ROM to ensure that appropriate interventions are in place. Audit will consist of 5 residents once a week x4 weeks, then every other week x2 months, then monthly x 3 months. 4. For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. 5. Compliance Date: 8/30/24	

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	but were not limited to, hemiplegia (paralysis) and hemiparesis (weakness) affecting the right dominant side and cerebral vascular accident (CVA). The face sheet for Resident 16 provided from the discharging facility, dated 6/3/24, had a picture of the resident with a sling present on the right arm. The physician progress note from the discharging facility for Resident 16, dated 6/3/24, indicated the resident denied any pain or increased weakness to right side and right hand was in the sling. The resident reported pain control was adequate. The resident had right sided hemiplegia and right lower extremity decreased ROM. The resident had a mild contracture of the right upper extremity and limited use of the right hand. The resident was up in a wheelchair with a sling. The admission Minimum Data Set (MDS) assessment for Resident 16, dated 6/18/24, indicated the resident had the ability to make himself understood and was able to understand others. The resident had limited function in range of motion and had impairment on one side of the upper and lower extremities. The resident required substantial assistance with upper body dressing (helper does more than half of the effort). The resident was admitted to the facility on 6/12/24. The plan of care for Resident 16, dated 6/25/24, indicated the resident had impairment in functional status related to a cerebral vascular accident (CVA) with hemiplegia. The interventions included, but were not limited to, encourage resident to be as independent safely as possible, medications as ordered, provide assistance as needed with self-care and mobility, and therapy evaluation/treatment as needed. The			

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	plan of care did not address the utilization of a sling. The plan of care for Resident 16, dated 6/25/24, indicated the resident had a diagnosis of cerebrovascular accident with hemiparesis/hemiplegia and required assistance with activities of daily living. During an interview with the Executive Director (ED) on 8/13/24 at 11:05 a.m., they indicated the facility had no policy for ROM, splints, or contractures. 3.1-42(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			

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	Based on observation, interview, and record review the facility failed to provide fortified food and fortified shakes as recommended by the Registered Dietician (RD) and as ordered by the physician for a resident who had experienced significant weight loss for 1 of 2 residents reviewed for nutrition (Resident 34). Findings include: The clinical record for Resident 34 was reviewed on 8/9/24 at 11:20 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis), hemiparesis (one-sided muscle weakness), ataxia (loss of muscle control), polyosteoarthritis, pulmonary fibrosis, and hypothyroidism. The clinical record for Resident 34 was reviewed on 8/9/24 at 11:30 a.m. The following weights were noted: 6/1/24 of 131.8 pounds, 7/2/24 of 129.8 pounds, and 8/2/24 of 122.6 pounds. This indicated the resident lost 6.98 % body weight in two months and lost 5.5 % body weight in one month. The quarterly Minimum Data (MDS) assessment for Resident 34, dated 7/26/24, indicated the resident was severely impaired for daily decision making. A physician order for Resident 34, dated 8/8/24, indicated the resident was ordered fortified food with puree texture. The plan of care for Resident 34, dated 8/8/24 indicated the resident had experienced a significant weight loss. The interventions included, but were not limited to, provide diet and supplements.	F 0692	F692 1. Resident #34 dietician recommendations were reviewed, and orders updated accordingly by Dietary Manager 2. Dietary recommendations for the last 30 days reviewed for in house residents to ensure all orders with recommendations were executed per the MDs approval. Licensed nurses will be educated on the policy for dietary recommendations. 3. As a measure of ongoing compliance, DHS/Designee to audit new dietary recommendations to ensure they are completed timely. Auditing will consist of 5 residents once a week for 4 weeks, once every other week x 2 months and then monthly x 3 months. 4. For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. 5. Compliance Date: 8/30/24	08/30/2024

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	The RD assessment for Resident 34, dated 8/8/24, indicated the resident had a 5% weight loss in one month that was not physician prescribed. The recommendation was for the resident to receive fortified foods and include fortified shakes with meals to promote protein and calorie intake and reweigh the resident. During an observation on 8/9/24 at 12:29 p.m., Resident 34 did not have a shake with her meal. She had tea and water. During an observation on 8/12/24 at 12:17 p.m., Resident 34 was in the assisted dining room. She had a pureed diet with a divided plate. The resident had eaten approximately a quarter of her food. The resident did not have a fortified shake. She had tea and water. During an interview with the Dietary Manager on 8/12/24 at 2:14 p.m., they indicated when a resident was ordered fortified food and fortified shake the dietary department would get a diet order from nursing for a diet change. The Dietary Manager indicated he was not aware Resident 34 was supposed to be provided fortified food and fortified shake. The Dietary Manager indicated Resident 34 had not been receiving fortified foods or fortified shakes. During an interview with the Director of Health Services (DHS) on 8/12/24 at 2:32 p.m., they indicated nurses were responsible for printing out Resident 34's diet order and provide it too dietary. The DHS indicated the nursing staff were responsible to reweigh as recommended by the RD and it was not completed. The weight policy provided by the DHS, on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155759	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

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	8/13/24 at 10:48 a.m., indicated the purpose was to ensure resident weight was monitored for weight loss to prevent complications arising from compromised nutrition. 3.1-46(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey Dates: August 7, 8, 9, 12, and 13, 2024. Facility Number: 011187 Residential Census: 25 Glen Oaks Health Campus was found to be in substantial compliance with 410 IAC 16.2-5 in regards to the State Residential Licensure Survey. Quality review completed on August 15, 2024.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Recertification Survey. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 30th,2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	