STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BYRON HEALTH CENTER	1661 BEACON STREET FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00410050. This visit also included a State Residential Licensure Survey. Complaint IN00410050 no deficiencies were cited. Survey dates: June 12, 13,14,15, and 16, 2023. Facility number: 000255 Provider number: 155364 AIM number:100273280 Census Bed Type: SNF/NF:100 Residential:48 Total:148 Census Payor Type: Medicare:3 Medicaid:142 Other:3 Total:148 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 21, 2023	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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

Sarah Starcher | Executive Director/COO | 07/06/2023

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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	facility must 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 observation, interview, and record review the facility failed to ensure comprehensive assessments were performed related to skin conditions for 1 of 3 residents reviewed. (Resident 65). Findings include: During an observation on 6/12/23 at 12:14 PM the following was observed: Resident 65 had a dime-sized dry, scabbed area on the right palm-side of the wrist. The resident indicated he wore a wrist brace frequently. Resident 65's record was reviewed on 6/12/23 at 2:15 PM. Diagnoses include scoliosis (curvature of the spine), contracture of muscle (stiffening of muscles due to lack of use), and muscle weakness. Resident 65's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 13 (cognitively intact). There was no current care plan to address Resident 65's abrasion to the right wrist. Current physician orders indicated there were no orders to assess the skin under the splint for Resident 65's contracture of their right hand. Progress notes dated 6/12/2023 at 5:53 PM indicated Resident 65's right hand was clean, dry, and intact. There were no progress notes to indicate the scabbed area on Resident 65's wrist right wrist had been assessed, when the area had	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff expected to initiate and document assessments related to skin conditions will be educated on ensuring appropriate interventions are initiated and documented for changes in skin condition. (Attachment 1) **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who experience change in skin conditions have the potential to be affected by the deficient practice. All nursing staff expected to initiate and document assessments related to skin conditions will be educated on ensuring appropriate interventions are initiated and documented for changes in skin condition. (Attachment 1) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee	07/06/2023

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	been discovered, the characteristics of the area, if physician and family notification had been completed. In an interview on 6/13/23 at 2:02 PM, Employee 5 indicated the right wrist had a scabbed area with pink surrounding tissue. A current policy dated 6/16/23 provided by the Administrator titled Skin Tears - Abrasion and Minor Breaks, indicated to record the following in the residents' medical record: 1. The site and description of the abrasion or wound. 2. The date and time the abrasion was discovered. 3. The date and time the injury occurred, if known. 4. The date and time the wound care was given. 3.1-37		to audit documentation related to skin assessment for 10% of residents monthly times six months to determine compliance with assessment and documentation. (Attachment 2). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit documentation related to skin assessment for 10% of residents monthly times six months to determine compliance with assessment and documentation. (Attachment 2). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.	
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			

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	§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 ensure range of motion exercises and therapy devices were completed as ordered for 1 of 2 residents reviewed. (Resident 65) Findings include: In an observation of Resident 65 on 6/12/23 at 10:15 he did not have splint in his right hand. Resident 65's right hand was contracted. Resident 65's left and right foot had foot drop. During an interview with Resident 65 on 6/12/23 at 12:15 he indicated the staff do not always do his exercises, nor do they use his splint consistently. Resident 65 was alert and oriented x3 throughout the interview. Resident 65's record was reviewed on 6/13/23 at 3:37PM. His current quarterly MDS (MDS) Minimal Data Set assessment dated 5/13/23 indicated the following: Section C- Cognitive Patterns indicated Resident 65 BIMS score (Brief Interview of Mental Status) was 13. The score of 13 indicated minimal cognitive decline.	F 0688	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** An audit of range of motion exercises and therapy devices will be conducted for all residents who have orders for range of motions exercise and therapy devices. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents with range of motion exercises and therapy devices orders had the potential to be affected by this practice. An audit of range of motion exercises and therapy devices will be conducted for all residents who have orders for range of motions exercise and therapy devices. All nursing staff expected to initiate range of motion exercise and put therapy devices in place will be educated on ensuring range of motion	07/06/2023

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	Section E-Behavior indicated Resident 65 did not refuse care. Section G-Functional Status-indicated Resident 65 required extensive assist with many areas of daily living. Functional limitation in range of motion indicated there were no limitations in upper or lower extremities. Mobility devices indicated no assistive devices. The functional rehabilitation potential was not completed. Section I-Active Diagnosis- indicated Resident 65 had contracture of muscles at multiple sites. Resident 65's medication administration record and treatment administration record dated June 1st through June 13th, 2023, indicated the following: The order: Splint: apply splint/brace for 6 hours; staff to wash, rinse, dry, and apply lotion before splint application, scheduled for 6am. There was no documentation of completion on 6/1, 6/3, 6/4, 6/5, 6/6, 6/7, 6/9, and 6/10. The order: Active range of motion to left upper extremity to be completed every shift. There was no documentation of completion of range of motion exercises Between June 1, and June 10 , 2023. The order: Active range of motion to right upper extremity to be completed every shift was documented as completed once on 6/3 and once on 6/5. There was no other documentation of completion of exercises. Resident 65's record did not have documentation of any refusals of care.		exercises and therapy devices are completed as order (Attachment 3). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit range of motion exercise and therapy device documentation and effectiveness for 10% of residents with range of motion exercises and therapy device orders monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 4). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit range of motion exercise and therapy device documentation and effectiveness for 10% of residents with range of motion exercises and therapy device orders monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 4). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly	

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	Resident 65's current care plan had the focus of at risk for reduced joint mobility dated 9/29/22 with last revision to goal on 5/17/23. A goal was to have no contractures to left upper extremity and right shoulder and elbow. An intervention was to perform range of motion exercises as prescribed. A policy titled; "Range of Motion Exercises" dated October of 2010 was provided by the Administrator on 6/16/23 at 9:42AM. The policy indicated .... Documentation the following information should be recorded in the resident's medical record: 1. The date exercises were performed. 2. The name and title of the individual who performed the exercises. 3. The type of range of motion exercises completed. 4. Whether the exercise was active or passive. 5. The initials of the person who performed exercises. 6. How long the exercises were conducted. 7. Any problems or complaints made by the resident related to exercises. 8. If the resident refused the treatment, the reason why and the intervention taken. 9. The signature and title of the person recording the data. 3.1-42(a)(2)		meetings and the plan revised, if warranted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	483.65 of this subpart. Based on observation, interview, and record review the facility failed to ensure oxygen tubing was properly stored and labeled when not in use for 1 of 5 residents reviewed. (Resident 44) Findings include: During an observation on 6/12/23 at 9:56 AM oxygen tubing and a humidifier bottle about 1/3 full of water was observed attached to the oxygen concentrator in Resident 44's room next to her bed. No dates were observed on the bottle or tubing. The tubing was coiled on top of the oxygen concentrator with the last 6 inches of the tubing, including the nasal cannula, hanging over the front portion of the concentrator. The tubing was not in a labeled bag. In an interview on 6/12/23 at 9:56 AM, Licensed Practical Nurse (LPN) 2 indicated oxygen tubing and humidifier bottles should be changed weekly and dated when changed. She also indicated tubing not in use should be placed in a dated bag. She picked up an unlabeled plastic bag from Resident 44's bedside table across the room and placed the tubing in the bag. In an interview on 6/14/23 at 10:21 AM, the Administrator indicated oxygen tubing should be labeled, dated, and changed weekly. She also indicated the tubing should be stored in a labeled and dated plastic bag when not in use. Resident 44's record was reviewed on 6/14/23 at 8:58 AM. Diagnoses included chronic obstructive pulmonary disease, anoxic brain damage, not elsewhere classified, pneumonia, organism unspecified, and heart failure, unspecified.	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents on ordered oxygen had the potential to be affected by this practice. All nursing staff who store and label oxygen will be educated on ensuring oxygen is stored and label appropriately when not in use (Attachment 5). **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents on ordered oxygen had the potential to be affected by this practice. All nursing staff who store and label oxygen will be educated on ensuring oxygen is stored and label appropriately when not in use (Attachment 5). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit the storage and labeling of oxygen weekly times six months to determine compliance with proper storage and labeling (Attachment 6). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than**	07/06/2023

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	Resident 44's current quarterly MDS dated 4/27/23 indicated her BIMS (Basic Interview for Mental Status) score was unable to be obtained because Resident 44 was unable to complete the interview. The MDS indicated Resident 44 required total assistance of one to two staff to perform activities of daily living. Resident 44's current care plan titled "I am at risk for shortness of breath" indicated Resident 44 had a problem of shortness of breath, with a goal date of 7/19/23. Interventions included use of oxygen. Physician orders dated 5/2/23 indicated oxygen was ordered to be administered as needed at 2 liters per minute for aspiration pneumonia. Progress notes indicated oxygen was administered on 6/4/23, 6/5/23, 6/7/23, 6/8/23, and 6/10/23. Medication administration records dated 6/23 and treatment administration records dated 6/23 did not indicate tubing changes had been performed. A current policy titled Oxygen Administration dated October 2010 provided by the Administrator on 6/13/23 at 1:32 PM did not address tubing changes or storage of tubing while not in use. The Administrator indicated the facility did not have a policy pertaining to tubing changes and storage. 3.1-47 (a)(4)(5)(6)		**six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit the storage and labeling of oxygen weekly times six months to determine compliance with proper storage and labeling (Attachment 6). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.	
R 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the	R 0000		

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	Investigation of Complaint IN00410050. This visit also included a State Residential Licensure Survey. Complaint IN00410050 no deficiencies were cited. Survey dates: June 12, 13, 14, 15, and 16, 2023. Byron Health Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Recertification and State Licensure Survey and the Investigation of Complaint IN00410050. Quality review completed June 21, 2023			