STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. BUILDING 00 B. WING	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411600, IN00411033 and IN00410821. Complaint IN00411600 - No deficiencies related to the allegations are cited. Complaint IN00411033 - No deficiencies related to the allegations are cited. Complaint IN00410821 - Federal/State deficiencies related to the allegations are cited at F658. Survey dates: July 6 and 7, 2023. Facility number: 000143 Provider number: 155238 AIM number: 100283890 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 6 Medicaid: 51 Other: 7 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 13, 2023.	F 0000	It is the practice of this facility that we ensure services are provided or arranged by the facility as outlined by the comprehensive care plan. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans			

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

Jennifer Bailey | Administrator | 07/21/2023

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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	The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to provide adequate toenail care for 1 of 3 residents reviewed for toenail care (Resident B). Resident B's clinical record was reviewed on 7/6/23 at 6:28 a.m. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance, chronic obstructive pulmonary disease, chronic kidney disease, essential (primary) hypertension, and need for assistance with personal care. His current physician orders included he may be seen by a podiatrist as needed. A quarterly MDS (Minimum Data Set), dated 5/30/23, indicated he was severely cognitively impaired. He required extensive assistance for dressing and personal hygiene. He had a current care plan for his preference to be followed by in-house ancillary providers (7/7/23). His goal was he would cooperate with an in house examination for vision, podiatry, hearing and dental as needed daily through next review. His interventions included refer to providers as indicated (7/7/23). A podiatry examination and treatment note, dated 2/23/22, indicated he had painful nails on both feet. Both feet had thickened and discolored toenails. He had onychomycosis (nail fungus causing thickened, brittle, crumbly or ragged nails) and onychogryphosis (a disorder of nail plate growth that is characterized by an opaque, yellow-brown thickening of the nail plate with	F 0658	F 658 Services Provided Meet Professional Standards Resident B no longer lives in the facility. 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 that require foot care have the potential to be affected by the alleged deficient practice. All residents have been assessed for the need for toenail care and care was provided by the nursing staff or the resident was seen by the podiatrist. The podiatrist treated residents that required foot care on 7/6/23. The next podiatry visit is scheduled quarterly. 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 on “Foot Care” was reviewed by the IDT. An in-service was held for all nursing staff on the foot care policy and to report to the Director of Nursing the need for podiatry services. A performance improvement tool has been developed to audit (5) residents a week for the need for foot care services. How the corrective actions will be	07/21/2023

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	associated gross hyperkeratosis, elongation, and increased curvature. It is often described as a "ram's horn nail") to his toenails on both feet. Treatment at that time was reduction of nails and mechanical debridement. A Nurse Practitioner skin/wound note, dated 2/3/23 at 6:47 a.m. indicated his nail condition diagnosis was tinea unguium (onychomycosis). His plan of care with additional recommendations included routine foot care. The podiatrist visit dates provided by the SSD (Social Service Director) indicated the podiatrist was in the building on 8/25/22, 1/24/23 and 4/10/23. There was no record of the resident being seen by podiatry on these dates. A hospital podiatry progress note, dated 6/13/23, indicated Resident B was brought into the emergency room secondary to a fall. Podiatry was consulted due to severely thickened deformed painful toenails, which were not cared for appropriately at his skilled nursing facility. His nails were severely thickened hypertrophic dystrophic and brittle rams horn type nails and painful with palpation. There was mild dry hemorrhagic tissue at the base of the right second toenail with no acute signs of infection. The plan was debridement of nails one through five at bedside as well as possible. He would need to follow-up with a podiatrist for more aggressive care and debridement than could had been performed at the hospital bedside. During an interview with CNA 12, on 7/6/23 at 5:16 a.m., indicated she would normally trim the residents nails on their shower days.		monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) residents to ensure foot care has been completed. 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: 7/21/23.	

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	During an interview with CNA 5, on 7/7/23 at 9:00 a.m., she indicated Resident B did not like showers and she took over the responsibility to do his showers. His toenails were thick and built up and he didn't like to have them washed, as they were very sensitive. She would cut his fingernails but never touched his toenails because they were so thick. During an interview with the SSD, on 7/7/23 at 9:36 a.m., she indicated Resident B was seen by the podiatrist on 2/23/22, then the facility switched podiatry services in August of 2022. A consent to treat letter was sent to all the family members with a permission slip and a self-addressed envelope. She did not receive a consent back from his family. During a follow-up interview with the SSD, on 7/7/23 at 10:38 a.m., she indicated she did not follow up with every single family member for consent to treat, but she had called two family members this day to get consent to treat, because the podiatrist was in the building. During a follow up interview with CNA 5, on 7/7/23 at 11:48 a.m., she indicated she didn't remember telling the nurse about Resident B's long toenails. She assumed he was on the podiatrist list. His nails were so long, they got caught on his socks when she put them on him. During an interview with LPN 10, on 7/7/23 at 12:26 p.m., she indicated Resident B's toenails were long and thick, but did not cause him any pain. They would not be able to trim his toenails with nail clippers and he would had needed to see a podiatrist.			

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	A current policy, revised 9/22 and titled "Foot Care," provided by the Administrator, on 7/7/23 at 12:12 p.m., indicated the following: "...1. Residents will be provided with foot care and treatment in accordance with professional standards of practice...." This Federal tag relates to Complaint IN00410821.			