STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit included the Investigation of Complaints IN00427976 and IN00428412. Complaint IN0428412 - Deficiencies related to the allegations are cited at F692. Complaint IN0427976 - No deficiencies related to the allegations are cited. Survey dates: March 6 and 7, 2024. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 3 Medicaid: 50 Other: 19 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Eagle Valley Meadows respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 27, 2024.	
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			

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

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	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. Based on observation, interview, and record review, the facility failed to ensure a resident did not have significant weight loss for 1 of 8 residents reviewed for weight loss (Resident L). Findings include: On 3/7/24 at 11:29 a.m., Resident L was observed as Activity Assistance (AA) 9 assisted Resident L to a dining room chair. Resident L was observed walking on her own with a walker. AA 9 gave her a coloring page and crayons. She indicated lunch would be arriving soon. On 3/7/24 at 12:20 p.m., Resident L was observed to receive a regular lunch of three large sweet and sour meatballs, a deep fried eggroll, sugar snap peas, steamed rice, mandarin oranges, and vanilla ice cream. No one cut-up her food for her. No staff member directed, cued, or assisted her with eating. During a limited interview during lunch, on 3/7/24	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident L has been placed on Hospice. Meal tray card has been updated to reflect preferences. Resident L is receiving a regular diet with addition of supplements per resident preference and MD orders. Resident L receives cueing and encouragement when eating as needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	03/27/2024

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	at 12:35 p.m., Resident L indicated she was having trouble chewing her food and she did not like it. She had been observed taking very few and small bites from the eggroll and chewed for a long time. AA 9 asked Resident L what she wanted to eat. Licensed Practical Nurse (LPN) 4 responded for her, she will eat a peanut butter and jelly sandwich. Then, Resident L asked for a banana. On 3/7/24, AA 9 left to get alternative food for Resident L. She returned at 12:49 p.m. She provided the sandwich and a banana. Resident L took one bite of the sandwich, but she actively ate all of the banana. AA 9 provided another banana, and Resident L ate all of it too. On 3/7/24 at 10:35 a.m., Resident L's record was reviewed. She was admitted to the secured area of the facility on 12/21/23. Her diagnoses included, but were not limited to, encephalopathy (brain dysfunction due to a brain condition), Alzheimer's disease (progressive mental deterioration), and dementia ([loss of intellectual functioning, memory, and abstract thinking), dated 12/21/23. A new diagnosis, dated 1/19/24, was unspecified severe protein-calorie malnutrition (obvious significant muscle wasting, loss of subcutaneous fat). An admission progress note, dated 12/21/23, indicated Resident L's diet was a mechanical soft diet (soft and easy to swallow foods). A weight loss care plan, dated 12/21/23, indicated Resident L was at risk for unintentional weight loss related to Alzheimer's disease, dementia, chronic kidney disease (mild to moderate damage of the kidneys), and GERD (gastroesophageal reflux disease: condition where acidic gastric fluid		**action(s) will be taken:** All residents trending weight loss have the potential to be affected by the alleged deficient practices. 1x audit was completed for all residents trending weight loss. Regional Dietitian to conduct an in-service with DNS, RD, and nurse managers on or before 3/27/24 regarding policy for weight loss. Inservice nursing staff on providing assistance for meals and offer alternative meal options completed by DNS/designee on or before 3/27/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Regional Dietitian to conduct an in-service with DNS, RD, and nurse managers on or before 3/27/24 regarding policy for weight loss. Inservice nursing staff on providing assistance for meals and offer alternative meal options completed by DNS/designee on or before 3/27/24. Observational rounds by Customer Care Representatives/designee during each meal to ensure that	

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	flows backward into the esophagus). She received a regular diet with poor PO (by mouth) intake. A goal was to have a slow weight gain to reach a desired BMI of greater than or equal to 23. The approaches to this care plan, dated 12/27/23, included to provide Ensure Plus (concentrated calorie and protein beverage) 237 milliliters (mL) three times a day, fortified cereal at breakfast, and fortified pudding at lunch and dinner. A care plan, dated 12/21/23, indicated Resident L required assistance and/or monitoring AM/PM care, hydration, elimination, and nutrition. A care plan, dated 12/22/23, indicated Resident L required assistance with activities of daily living (ADLs) including bed mobility, transfers, toileting, and eating. The goal indicated Resident L had a desire to improve her current functional status. An approach indicated to assist her with eating and drinking as needed. A Medicare Charting Note, dated 12/26/23 at 9:41 a.m., indicated Resident L fed herself with set-up help. A Nutrition Admission Assessment, dated 12/27/24 at 12:03 p.m., indicated diagnoses that may increase nutritional risk included, but not limited to, encephalopathy, Alzheimer's disease, dementia, hyperlipidemia (high concentrations of fat in the blood), hypertension (high blood pressure), chronic kidney disease, stage 3, vitamin D deficiency. Her current body weight was 70.4 pounds on 12/22/24 with a BMI (body mass index) as an underweight status for advanced age. The physician's orders were atorvastatin (lower cholesterol levels), Vitamin D3, Vitamin B12, and omeprazole (treats acid reflux). Resident L received a regular diet. Her estimated nutritional		residents requiring assistance with eating and meal alternatives is being provided as needed. Residents with trending weight loss will be reviewed during NAR weekly attended by IDT. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure compliance the DNS/Designee will complete a Significant Weight Change CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Significant Weight Change CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By what date the systemic changes will be completed:** 3/27/2024	

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	needs were 1120-1184 k/cal/kg (unit of measure for 1000 calories per kilogram by body weight), 32-38 grams of protein, 1120-1184 cc/kcal (milliliters) fluids. The resident may not meet her estimated needs. Recommend fortified cereal at breakfast, fortified pudding at lunch, and Ensure Plus 237 mL every day at breakfast to aid in kcal needs. Recent labs were reviewed with a glucose level of 55. The current nutritional goal was for the resident have a slow weight gain to reach a desire BMI of 23 and for the resident to consume more than 75% of at least two meals. The Registered Dietitian was to follow weights, average PO intake, and honor dietary preferences. A Nurse Practitioner (NP) 13 note, dated 12/28/24 at 1:05 p.m., indicated Resident L had no loss of appetite. Her Complete Metabolic Panel (CMP) lab, dated 12/28/24, indicated her glucose level was 55. No follow-up was observed in the medical record. The Registered Dietician's note (RD), dated 1/3/24, indicated RD 12 had a nutrition observation of Resident L. Her physician orders indicated a regular diet with Ensure Plus, 237 mL, dated 1/11/24, twice daily. On 3/7/24 at 3:19 p.m., the DNS provided the electronic Medical Administration Record (MAR) for Resident L's consumption of Ensure Plus nutritional supplement. It was ordered on 1/11/24. The January 2024 MAR indicated Resident L's Ensure Plus was not administered due to refusal on 1/11, 1/20, 1/24, 1/25, 1/27, 1/28, 1/30, and 1/31/24.			

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	The February 2024 MAR indicated Resident L's Ensure Plus was not administered due to refusal on 2/1, 2/5, 2/6, 2/7, 2/8, 2/10, 2/11, 2/13, 2/14, 2/19, 2/20, 2/21, 2/22, 2/24, and 2/25/24. The March 2024 MAR indicated Resident L's Ensure Plus was not administered due to refusal on 3/4, 3/5, 3/6, and 3/7/24. On 3/7/24 at 3:26 p.m., Resident L's admission Minimum Data Set (MDS), dated 12/27/23, indicated her cognitive skills for daily decision making was severely impaired. Her eating performance indicated she needed partial/moderate assistance. Another physician's order indicated Mirtazapine tablet (antidepressant) 7.5 mg, dated 2/20/24, at bedtime for an appetite stimulant. Her weight, on admission, was 70.4 pounds. Her weight on 1/21/24 was 69.6 pounds, on 2/6/24 was 61.8 pounds, and on 3/4/24 was 57.4 pounds. She lost 13 pounds in 74 days, 18.5% of her body weight. Her POC (point-of-care) charting for eating indicated Resident L had set-up and supervision only from 3/1/24 to 3/7/24. A Medicare Charting note, dated 3/5/24 at 9:43 a.m., indicated Resident L needed extensive assistance with ADLs. Her meal consumption was 0-25%. A progress note, dated 3/5/24 at 9:54 a.m., indicated Resident L fed herself with set-up help, appetite poor, with supplements in place but refused.			

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	On 3/7/24 at 11:15 a.m., the Executive Director (ED) provided a document listing the resident's in the facility that needed or may have needed assistance with eating. Resident L was not on that list. On 3/7/24 at 1:40 p.m., the Director of Nursing Services (DNS) provided the discharge notes from the local hospital, with a discharge date of 12/21/23. The Final Report indicated Resident L's diet was listed as a general diet, but also indicated FEN (fluid, electrolytes, nutrition): Dysphagia, Level 6 diet (soft and bite sized pieces of food, used if not able to bite off pieces of food safely but are able to chew bite sized pieces down into little pieces that are safe to swallow). The DNS indicated the mechanical soft diet, found in the admission progress note, could have come from the hospital discharge report. On 3/7/24 at 1:43 p.m., RD 12 indicated she had observed Resident L eating before and did not see her choking on her food. On 3/7/24 at 2:00 p.m., the DNS indicated Resident L's diet from the hospital was a dysphagia level 6 diet for regular food. She indicated the RD told her level 6 diet meant soft food, bite sized pieces. On 3/7/24 at 3:58 p.m., RD 12 indicated the facility should have contacted her if Resident L's weight changed. She was a slow eater and picked at her food, she ate her food with small bites. She was given pudding for a soft consistency food. Her BMI was 11 and should have been 23 or above. Her hospital discharge notes indicated she was an IDDSI (International Dysphagia Diet Standardization Initiative) Level 6. The facility should have called the hospital for clarification			

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	since it indicated a general diet and a Level 6 diet. On 3/6/24, the ED provided a potential for abuse reportable that the facility deemed not substantiated. Review of the reportable showed, information from CNA 10, in writing to the DNS, indicating after assisting another (unidentified) resident with eating CNA observed Resident L's food was sitting in front of her and she had not touched the food. CNA 10 helped Resident L eat a little since the resident usually did not eat. CNA 10 indicated when feeding Resident L, she would take little bites, even if she said no. CNA 10 indicated she saw the resident had lost weight so CNA 10 encouraged the resident to eat, and she opened her mouth when CNA 10 gave her some food. On 3/8/24 at 1:46 p.m., the ED provided the Speech Therapy evaluation from 12/22/23 to 1/20/24. A review of this document indicated her diagnoses were, " ...Alzheimer's disease with late onset ...cognitive communication deficit ...Global Deterioration Scale (GDS) - 5/7 - Mod-Sev cognitive decline ...How often does patient function safely without additional assistance/supervision due to cognitive deficits? = 0-25% of the time ...Pt able to follow directions for daily tasks will set up and verbal cues ...." On 3/7/24, a feeding assistance policy was requested from the ED and not received prior to exit. This citation relates to Complaint IN0428412. 3.1-46(a)(1)			