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	09/30/2022

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 IN00382961, IN00383520, and IN00390759. Complaint IN00382961 - Unsubstantiated due to lack of evidence. Complaint IN00383520 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00390759 - Substantiated. Federal/state deficiencies related to the allegations are cited at F686 and F690. Survey dates: September 29 and 30, 2022 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 5 Medicaid: 53 Other: 7 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/3/22.	F 0000	By submitting the enclosed material, 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 10-17-22 to Investigation of Complaints survey IN00390759 completed on September 29 to September 30, 2022. We respectfully request a paper review and will provide any additional information requested.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

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

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	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure a resident admitted with a pressure ulcer received the necessary treatment and services to prevent further breakdown related to providing preventative measures, the lack of documentation of turning, repositioning, and transferring the resident out of bed which resulted in an unstageable necrotic pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident C) Finding includes: The closed record for Resident C was reviewed on 9/29/22 at 11:00 a.m. The resident was admitted to the facility on 4/22/22 from the hospital. Diagnoses included, but were not limited to, atrial fibrillation, high blood pressure, dysphagia, obstructive uropathy, peg tube, stroke, aphasia, and hemiplegia. The Admission Minimum Data Set (MDS) assessment, dated 4/29/22, indicated the resident was rarely understood and rarely understands. The resident was an extensive assist with a 2 plus	F 0686	Chesterton Manor respectfully requests that this citation be reviewed under the Informal Dispute Process related to F686 regarding pressure areas. Although we disagree that facility practices caused the pressure ulcer, the facility will work the plan of correction accordingly. The facility contends that preventative measures were in place to prevent the development of pressure ulcers and that lack of documentation because of agency does not mean that services were not provided. F686 It is the practice of this facility to ensure a resident receives care consistent with professional standards of practice for the prevention and treatment of pressure ulcers.	10/17/2022

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	person physical assist for bed mobility, and toilet use. The resident had 1 unhealed pressure ulcer which was a deep tissue injury (DTI) that was present on admission. A Braden Pressure Scale assessment, dated 4/28/22, indicated the resident was at risk for pressure ulcers. The resident was slightly limited with cognition, was occasionally moist, and required an extra linen change approximately once a day. The resident was slightly limited with mobility and made frequent, though slight changes in body or extremity position independently. The resident's nutrition was adequate. A Braden Pressure Scale assessment, dated 5/5/22, indicated the resident at moderate risk for pressure ulcer. The resident now required moderate to maximum assistance in moving. Complete lifting without sliding against sheets was impossible, frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. A Care Plan, dated 4/22/22, indicated the resident had potential/actual impairment to skin integrity. A Care Plan, dated 4/22/22, indicated the resident had an Activities of Daily Living self care performance deficit related to a stroke. The approaches were to assist with turning and repositioning as needed. A Care Plan, dated 4/22/22, indicated the resident had a chronic foley catheter. A Nursing Evaluation Admission Assessment, dated 4/22/22, indicated the resident had a scab below the left knee and bruising to the abdomen.		The corrective action taken for those residents found to be affected by the deficient practice include: Resident C was discharged to home on 9/9/22 with a 10 day supply of wound care supplies, DME orders for electric bed with air mattress and reclining high back wheelchair with air cushion. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken: All charts were reviewed to identify other residents having pressure ulcers and that preventative measures were in place. Tasks were added to those residents' charts for completion of documentation that turning and repositioning was being completed. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nursing staff have been in-serviced on the treatments and services necessary to prevent further skin breakdown for residents with pressure ulcers, including but not limited to, turning, repositioning, transferring the resident out of bed, mattress types and other pressure reducing/relieving devices. A random audit will be completed to ensure preventative measures are	

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	A Nurses' Note, dated 4/25/22 at 11:15 a.m., indicated a head to toe skin assessment was completed. The resident had a scab to the right knee and a deep tissue injury (pressure ulcer) to the elbow. Physician's Orders, dated 4/25/22, indicated right elbow cleanse with normal saline, pat dry and apply skin prep daily. May apply as needed every shift. one time a day for wound care and every 12 hours as needed. A Wound Observation, dated 4/25/22, indicated the resident was admitted with a deep tissue injury (pressure ulcer) to the right elbow. The ulcer measured 5 centimeters (cm) by 4 cm. A Wound Observation, dated 5/9/22, indicated the right elbow pressure ulcer measured 4 cm by 3 cm. The area was healed on 5/16/22.. A Registered Dietitian's (RD) Note, dated 4/28/22 at 11:35 a.m., indicated the resident was a new admission. The resident was NPO (nothing by mouth) and was receiving an enteral feeding through the peg tube (a tube inserted directly into the stomach for nutrition). The enteral feeding provided 100% of nutrition and hydration for the resident. The RD indicated there were no pressure injuries and his weight was 181 pounds with a body mass index of 26.7. The resident would have weekly weights and would be monitored by NAR (Nutrition at Risk). An RD Note, dated 5/4/22 1:39 p.m., indicated the resident remained NPO and enteral feedings were adequate. There were no new recommendations. There was no information regarding any pressure ulcers.		in place and turning and repositioning is being completed. How the corrective action will be monitored to ensure the deficient practice will not recur: A Performance Improvement Tool has been initiated that randomly observes 5 residents with pressure ulcers for the appropriate completion and documentation of turning/repositioning and that preventative measures are in place. The Director of Nursing or designee will complete these tools weekly X3, monthly X3, then quarterly X3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be complete: 10/17/22	

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Physician's Orders, dated 4/25/22, indicated 16 Fr (French) foley catheter with 10 cc (cubic centimeters) balloon. May change as needed for leakage, dislodgement or occlusion.

Physician's Orders, dated 4/28/22, indicated Jevity 1.5 bolus (237 milliliters) every 4 hours.

Nurses' Notes, dated 5/11/22 at 8:28 a.m., indicated the resident was observed with a pressure ulcer to the left buttock.

A Wound Observation, dated 5/11/22, indicated an acquired pressure ulcer to left buttock that measured 7 cm by 5 cm. The pressure ulcer was described as unstageable with 100% black necrotic tissue.

A Nurses' Note, dated 5/11/22 a 10:53 a.m., indicated the Interdisciplinary Team (IDT) met to review the pressure ulcer to the left buttock. The Physician and family were made aware. New orders were received for the Wound Physician to evaluate and treat, an air mattress was applied to the bed, the RD was consulted and orders for liquid protein received. The Wound Nurse was to follow.

There were no Physician's Orders for a liquid protein supplement or a specialty air mattress prior to the development of the unstageable pressure ulcer on 5/11/22.

The 5/20/22 Bed Mobility (turning and repositioning) Task for ADLs indicated there was no documentation the resident was turned or repositioned on the day shift on 5/1, 5/2, 5/8, and 5/9/22. There was no documentation on the evening shift on 5/5, 5/7, and 5/11 and on the

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	midnight shift on 5/1, 5/5, 5/9 and 5/10/22. The Bed Mobility Task was only signed out 1 time during the day on 5/3-5/8/22, on evening shift 5/1-5/4, 5/6, and 5/8-5/10/22, and on the midnight shift on 5/2, 5/3, and 5/6-5/8/22 The 5/20/22 Transfer Task for ADLs for all three shifts was coded with an "8" indicating the task did not occur. A Wound Physician Note, dated 5/16/22, indicated it was an initial visit for an unstageable left medial buttock pressure ulcer. The ulcer measured 5 cm by 2.5 cm by unstageable and had 100% thick adherent necrotic tissue. Interview with the Wound Nurse on 9/29/22 at 2:50 p.m., indicated she was "livid" when she saw the resident had a black necrotic unstageable pressure sore. The facility staffed with mostly Agency Staff and she cannot 100% say the resident was being turned and repositioned every 2 hours. The resident had an indwelling foley catheter and was NPO and received all nutrition through the peg tube. The resident did not speak but could let his needs be known by pointing or nodding. The Wound Nurse indicated barrier cream after each incontinent episode was to be applied and the RD would see the resident when they were high risk for break down. Interview with the Director of Nursing on 9/29/22 at 2:50 p.m., indicated all of the regular mattresses were pressure reducing. The air mattress was ordered for the resident on 5/11/22. Staff were to reposition, check and change the resident every 2 hours, and she could not say that was being done all the time with all of the Agency Staff in the building.			

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	Interview with the Wound Nurse on 9/29/22 at 3:30 p.m., indicated she had "dropped the ball" and did not order the air mattress until 5/11/22. This Federal tag relates to Complaint IN00390759 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal			

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	incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure catheter care was documented for 1 of 3 residents reviewed for infections. (Resident K) Finding includes: The record for Resident K was reviewed on 9/29/22 at 2:18 p.m. Diagnoses included, but were not limited to, urinary tract infection, prostate cancer, and urinary retention. The Quarterly Minimum Data Set (MDS) assessment, dated 6/22/22, indicated the resident was cognitively impaired for daily decision making and he had use of an indwelling catheter and an ostomy. The resident had also received antibiotics during the assessment reference period. A Care Plan, dated 2/11/21, indicated the resident had a suprapubic urinary catheter due to prostate cancer. Interventions included, but were not limited to, provide catheter care per facility policy. A Physician's Order, dated 9/27/22, indicated the resident was to receive Suprax (an antibiotic) 400 milligrams (mg) daily for a urinary tract infection (UTI) for 10 days. A Physician's Order, dated 11/26/21, indicated the resident was to receive catheter care every shift during routine CNA care.	F 0690	F690 It is the practice of this facility to ensure a resident receives catheter care consistent with professional standards of practice. The corrective action taken for those residents found to be affected by the deficient practice include: Catheter care was added to the task list of Resident K for completion of documentation that catheter care was provided. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken: All charts were reviewed to identify other residents having catheters. Tasks were added to those residents' charts for completion of documentation that catheter care was provided. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nursing staff have been in-serviced regarding completion of catheter care with appropriate documentation. A random audit will be completed to ensure	10/17/2022

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	There were no orders for catheter care listed on the July, August, and September 2022 Treatment Administration Records (TAR's). There was no documentation of catheter care in the "Task" section which was completed by the CNA's. Interview with the Director of Nursing on 9/29/22 at 3:00 p.m., indicated the resident's catheter care should have been completed as ordered and documented in the "Task" section by the CNA's. This Federal tag relates to Complaint IN00390759. 3.1-41(a)(1)		catheter care is being provided. How the corrective action will be monitored to ensure the deficient practice will not recur: A Performance Improvement Tool has been initiated that randomly observes 5 residents with catheters for the appropriate completion and documentation of catheter care. The Director of Nursing or designee will complete these tools weekly X3, monthly X3, then quarterly X3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be completed: 10-17-22	