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	11/15/2022

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		F 0000		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00390759 completed on 9/30/22.

This visit was in conjunction with the Investigation of Complaint IN00393843.

Complaint IN00390759 - Not corrected.

Complaint IN00393843 - Substantiated. Federal/state deficiencies related to the allegations are cited at F609 and F943

Unrelated deficiency is cited.

Survey dates: November 14 & 15, 2022

Facility number: 000150
Provider number: 155246
AIM number: 100267000

Census Bed Type:
SNF/NF: 62
Total: 62

Census Payor Type:
Medicare: 10
Medicaid: 48
Other: 4
Total: 62

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on 11/18/22.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Winebrenner	RN	12/01/2022

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §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 observation, record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to prevent further breakdown of the skin and to ensure interventions to assist with the continued healing of the pressure ulcers were administered, related to lack of documentation of turning and repositioning and providing nutritional supplements as ordered by the Physician, for 2 of 3 residents reviewed for pressure ulcers. (Residents D and J) Findings include: 1. During an observation on 11/14/22 at 9:48 a.m. with the Wound Nurse, Resident D was lying in bed on her back. The bed had a low air loss mattress. The resident was given slow instructions on how to turn to her side and was able to hold onto the mobility rail to help hold herself over. The Wound Nurse lifted her right leg over to assist her in turning to her left side. There	F 0686	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 12-1-22 to Investigation of Complaints survey IN00393843 and PSR for Investigation of Complaint survey IN00390759 completed on November 14 to November15, 2022. We respectfully request a paper review and will provide any additional information requested.	12/05/2022

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	was a hydrocolloid dressing observed on the sacrum area. The Wound Nurse indicated the resident was turned by the staff and after about 10 minutes she would turn herself back over on her back. Upon leaving the room, the resident was turned back onto her back. No assistive devices were used to comfortably position the resident on her side. The resident was observed lying in bed on her back on 11/14/22 at 11:54 a.m. and 2:30 p.m. On 11/15/22 she was observed lying in bed on her back at 8:10 a.m., 9:30 a.m., and 10:17 a.m. Resident D's record was reviewed on 11/14/22 at 2:54 p.m. The diagnoses included chronic kidney disease, diabetes mellitus, and dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 10/26/22, indicated a severely impaired cognitive status, no behaviors, required extensive assistance of two for bed mobility, had an unhealed pressure ulcer and one deep tissue injury on admission, and received hospice care. A Care Plan, dated 10/14/22 and revised on 10/26/22, indicated a deep tissue injury was located on the sacrum area. The interventions included diet and supplements would be administered as ordered. Turning and repositioning and the use of turning/repositioning devices were not included as interventions on the Care Plan. A Wound Evaluation, dated 10/20/22, indicated an unstageable deep tissue injury was on the sacrum, which measured 1.5 centimeters (cm) by 4.0 cm. The Wound Specialist Note, dated 11/7/22,		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. The corrective action taken for those residents found to be affected by the deficient practice include: The care plans for resident D and J were revised to include turning and repositioning and the use of positioning devices. Turning and repositioning has been included on the chart orders to be signed off by the nurse or QMA. The orders for nutritional supplements were reviewed for resident D and are present on the orders to be signed off by the nurse or QMA. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken: All resident with pressure ulcers have the potential to be effected. A review of charts on these residents was completed to include interventions on the care plan for turning and repositioning and positioning devices. Orders were added to those residents' charts for documentation that turning and repositioning was being completed. Turning and repositioning has been added to CNA assignment sheets for all residents with pressure areas.	

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	indicated the sacrum wound was 0.6 cm by 0.3 cm. and a hydrocolloid dressing was administered three times a week. The Physician's Orders indicated the following nutritional supplements: On 10/14/22, megestrol (appetite stimulant) 625 mg (milligrams) daily On 10/19/22, Magic Cup three times daily On 10/20/22, liquid protein 30 cc (cubic centimeters) daily The Medication Administration Record (MAR), dated 10/2022, indicated the liquid protein, megestrol, and Magic Cup had not been administered on 10/30/22. The MAR, dated 11/2022, indicated the liquid protein, megestrol, and Magic Cup had not been given on 11/1/22 and 11/11/22. The Turning and Repositioning Task Form, dated 10/2022, indicated the resident had not been turned and repositioned on the night, day and evening shifts from 10/17/22 to 10/26/22. There had also been no turning or repositioning completed on the following shifts: 10/27/22 on the night shift. 10/29/22 on the evening shift. 10/31/22 on the evening shift. The Turning and Repositioning Task Form, dated 11/2022, indicated there had been no turning or repositioning completed on the following shifts: 11/1/22 on the day shift. 11/2/22 on the evening shift. 11/3/22 on the day and evening shift. 11/4/22 on the night and evening shift. 11/5/22 on the day shift. 11/6/22 on the day and evening shift		Nutritional supplements are present on the chart orders for nursing to document consumption. 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, supplements, positioning devices and other pressure reducing/relieving devices. A random audit will be completed to ensure preventative measures are in place and turning and repositioning, administration of nutritional supplements is being completed and documented properly. 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 administration of nutritional supplements. 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	

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	11/7/22 on the day shift. 11/8/22 on the day shift. 11/10/22 on the day shift. 11/11/22 on the day shift. 11/12/22 on the day shift. 11/14/22 on the evening shift. 2. Resident J was observed on 11/15/22 at 9:00 a.m. lying in bed on his back with the head of the bed elevated. The bed had a low air loss mattress. During an interview on 11/15/22 at 9:30 a.m., the Administrator indicated the resident was turned but he would turn himself back onto his back. Resident J's record was reviewed on 11/15/22 at 1:45 p.m. The diagnoses included, but were not limited to, stroke and diabetes mellitus. A Quarterly MDS assessment, dated 11/8/22, indicated no long term or short term memory problems, no behaviors, required extensive assistance of two for bed mobility, and had one deep tissue injury. A Care Plan, dated 10/20/22 and revised on 10/27/22, indicated the sacrum area had a deep tissue injury. The interventions included a pressure reducing air mattress would be applied to the bed. Turning and repositioning and the use of turning/repositioning devices were not included as interventions on the Care Plan. A Wound Evaluation, dated 10/19/22, indicated the sacrum area measured 5 cm by 6 cm and was a deep tissue injury. On 11/14/22, the sacrum area measured 1.5 cm by 1.5 cm.		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: 12/5/22	

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	The Turning and Repositioning Task Form, dated 10/2022, indicated the resident had not been turned and repositioned on the night, day and evening shifts from 10/17/22 to 10/26/22. There had also been no turning or repositioning completed on the following shifts: 10/27/22 on the night shift. 10/28/22 on the day and evening shift. 10/29/22 on the day shift. 10/30/22 on the day shift. 10/31/22 on the evening shift. The Turning and Repositioning Task Form, dated 11/2022, indicated there had been no turning or repositioning on the following shifts: 11/2/22 on the evening shift. 11/4/22 on the night, day and evening shift. 11/5/22 on the day and evening shift. 11/6/22 on the day and evening shift. 11/7/22 on the day and evening shift. 11/9/22 on the night and evening shift. 11/10/22 on the day and evening shift. 11/11/22 on the night shift 11/12/22 on the night and day shift. 11/14/22 on the day shift. During an interview on 11/15/22 at 2:57 p.m., the Director of Nursing, indicated she had been monitoring that the residents were being turned daily, not every shift. A Skin and Wound Management policy, dated 4/2017 and received from the Director of Nursing as current, indicated residents who were identified with skin impairments would have appropriate interventions implemented to promote healing. The Care Plan would identify the interventions implemented and would be updated as needed and was to include positioning requirements.			

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	This deficiency was cited on 9/30/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of			

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	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure residents with urinary catheters and history of urinary tract infections (UTIs) received proper care and services related to improper catheter tubing positioning, care plan interventions not followed for catheter usage, and catheter care not provided every shift, for 2 of 3 residents reviewed with urinary catheters. (Residents E and F) Findings include: 1. On 11/15/22, Resident E was observed sitting in a wheelchair in the Dining Room from 8:45 a.m. to 10:00 a.m. The urinary catheter drainage bag (not a leg bag) was uncovered and attached to the back of the wheelchair. When the resident had his legs pulled in, the catheter tubing would be lying on the floor. When his legs were extended, the catheter tubing would not be touching the floor. He was seen with the catheter tubing touching the floor at 8:45 a.m., 9:15 a.m., 9:34 a.m., 9:37 a.m., 9:43 a.m., and 10:00 a.m. The urine in the catheter bag was yellow and the tubing had urine with sediment observed. During an interview on 11/15/22 at 10:00 a.m., the Administrator acknowledged the tubing placement and the uncovered urinary catheter bag. Resident E's record was reviewed on 11/15/22 at 8:51 a.m. Diagnoses included, but were not limited to, urinary retention, history of UTI's, and dementia. An Annual MDS assessment, dated 9/22/22,	F 0690	It is the practice of this facility to ensure a resident receives catheter care and services consistent with professional standards of practice. The corrective action taken for those residents found to be affected by the deficient practice include: Resident E care plan was reviewed and updated to for correct drainage bag usage. CNA assignment sheet was updated to include catheter care every shift. Catheter care orders were added to the MAR to ensure for the appropriate completion and documentation of catheter care. A urinary catheter privacy bag was placed over the catheter bag and secured to resident wheelchair to prevent tubing from touching the floor. Resident F care plan was updated to reflect the intervention of catheter care every shift. Catheter care orders were added to the MAR to ensure for the appropriate completion and documentation of catheter care. CNA assignment sheet was updated to include catheter care every shift. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken:	12/05/2022

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	indicated long and short term memory problems, no behaviors, required extensive assistance of two for transfers, limited assistance of one for locomotion, and an urinary catheter was present. A Care Plan, dated 2/11/21, indicated a suprapubic catheter (drains urine from the bladder from a small hole in the abdomen) was present. The interventions included, catheter care was to be provided per the facility policy. A Care Plan, dated 8/2/19, indicated the resident would have, "episodes" of pulling out the suprapubic catheter. The interventions included using a leg bag during the day and catheter care would be completed every shift. The Care Form for the resident assignment, provided by CNA 1 on 11/15/22 at 9:39 a.m. and dated 11/4/22, indicated the resident had an urinary catheter. There were no instructions for catheter care or leg bag usage during the day. The Physician's Orders, dated 11/26/21, indicated catheter care was to be completed every shift. The CNA Task forms, dated 10/2022 and 11/2022, indicated the catheter care had not been completed on night shift on October 17, 2022, and November 4, 12, 13, and 14, 2022. The catheter care had not been completed on the day shift on October 18, 25, 30, 2022 and November 5, 6, 10, 11, 12, 13, and 14, 2022. The catheter care had not been completed on evening shift on October 17, 18, 20, 21, 22, 24, 28, and 30, 2022 and November 2, 3, 4, 10, and 13, 2022. 2. Resident F was observed lying in bed on 11/14/22 at 11:47 a.m. An urinary catheter drainage bag was located on the far side of the bed and		All charts were reviewed to identify other residents having catheters. Orders were added to those residents' charts for completion of documentation that catheter care was provided. All residents with catheters care plans have been reviewed and updated to reflect appropriate catheter interventions, including covering bag and placement of tubing. CNA assignment sheet were updated to include catheter care every shift for residents with catheters. 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 and services with appropriate documentation. The in-service included proper catheter care, proper positioning of catheters and tubing and the use of privacy bags for catheters. A random audit will be completed to ensure catheter care and services 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 and services including catheter care, positioning of catheter bag,	

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	contained cloudy yellow urine. The resident indicated the staff emptied the drainage bag during day, though was unsure if they washed the catheter tubing and insertion site during care. She indicated she "never really paid attention". Resident F's record was reviewed on 11/15/22 at 9:51 a.m. The diagnoses included, but were not limited to, history of UTI's and urinary retention. A Quarterly MDS assessment, dated 9/25/22, indicated an intact cognitive status, no behaviors, required extensive assistance of two for bed mobility and hygiene, and had an indwelling urinary catheter. A Care Plan, dated 2/18/22, indicated a suprapubic catheter was present. The interventions included, the catheter drainage was to below the level of the bladder and away from the entrance door to the room and the tubing was to be monitored for kinks every shift. The intervention of catheter care was not included on the care plan. The Care Form for the resident assignment, provided by CNA 2 on 11/15/22 at 9:29 a.m., indicated resident had a catheter. There were no instructions that catheter care was to be completed every shift. A Physician's Order, dated 9/29/22, indicated urinary catheter care was to be provided every shift and as needed. The CNA Task forms, dated 10/2022 and 11/2022, indicated the catheter care had not been completed on night shift on October 19, 26, 28, and 29, 2022 and November 4 and 12, 2022. The catheter care had not been completed on day shift on October 28, 2022 and November 1, 4, 5, 6, 8, 9,		positioning of catheter tubing, appropriate use of privacy bags and appropriate care plan interventions. 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: 12/5/22	

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	10, 11, and 12, 2022. The catheter care had not been completed on evening shift on October 18, 21, 24,, 27, 29, 30, and 31, 2022 and November 1, 2, 4, 5, 6, 9, and 10, 2022. During an interview on 11/15/22 at 2:57 p.m., the Director of Nursing indicated she had been monitoring to ensure the catheter care had been completed daily, not every shift. She acknowledged the Physician's Orders indicated catheter care was to be completed every shift. An undated Urinary Catheter Care policy, received as current from the Director of Nursing on 11/15/22 at 3:57 p.m., indicated the resident's care plan was to be reviewed for any special needs. The catheter tubing was to be kept off the floor. Catheter care was part of the routine nursing care, unless it was specifically ordered in the resident's chart. This deficiency was cited on 9/30/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-41(a)(1)			