STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155679	A. BUILDING 00 B. WING	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHLEHEM WOODS NURSING AND REHABILITATION	4430 ELSDALE DR FORT WAYNE, IN 46835

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 26, 27, 28, May 1 and 3, 2023 Facility number: 000260 Provider number: 155679 AIM number: 100267820 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 1 Medicaid: 47 Other: 29 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complaeted May 5, 2023	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before May 24, 2023	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JoElyn Louise Morris	Administrator	05/23/2023

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 resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record review the facility failed to be free of physical restraint for 1 of 1 resident reviewed. (Resident 29) Finding include: During an observation, on 4/26/23 at 10:04AM, Resident 29 was in the dining room of the memory care unit. Resident 29 was sitting in a chair with arms. The chair was up against a partial wall and the table was pulled up flush to Resident 29's stomach. There were peers in wheelchairs on each side of Resident 29 during this observation. Resident 29 could not get up, or away from the table. During an observation on 4/28/23 from 10:36AM to 11:05AM, Resident 29 was sitting in the armed chair in dining room. The chair was up against a	F 0604	F604 Right to be free from physical restraints *What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Seating placement for resident #29 was rearranged in the dining room to ensure she has space to move freely at all times. Education was provided to nursing staff r/t appropriate interventions for safety and positioning to ensure resident's movements are not restricted. No adverse effects were noted related to the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be*	05/24/2023

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	partial wall and the table was pulled up flush to Resident 29's stomach. There were peers in wheelchairs on each side of Resident 29 during this observation. In an interview on 4/28/23 at 10:56AM, RN 15 (Registered Nurse), indicated a restraint was the inability to move freely. The RN gave the example of someone in a wheelchair with the wheels locked and resident unable to unlock them. RN 15 indicated Resident 29 was restrained by the table, "but I don't know what to do about it". In an interview on 4/28/23 at 11:02AM, RN 17 indicated the incident described above was a physical restraint. In an interview on 4/28/23 at 11:16AM, with the RN 16, she indicated the issue has been resolved and the resident was currently sitting with a staff member for safety. Resident 29's record review, on 04/27/23 at 11:23 AM, indicated Resident 29 diagnoses included Alzheimer's, dementia, depression, and anxiety. Resident 29 had no care plan for restraints. Resident 29 did not have a doctor's order for restraints. Resident 29 did not have any progress notes or tracking observations regarding restraints during these observations. Resident 29's most recent MDS (Minimal Data Set assessment) included the following: Section C: BIMS assessment (Brief Interview for Mental Status) score was two. The BIMS score of		*identified and what corrective action will be taken:* All residents have the potential to be affected by the alleged deficient practice. No other residents found to be affected. Re-education was provided to all staff on the Physical Restraint Policy including appropriate positioning to ensure resident movements are not restricted. IDT/designee will utilize the Facility Leadership Safety/Positioning Rounding Tool daily x 1 week, then weekly x 4 weeks, and then monthly x 3 months. Any concerns during rounds may initiate additional corrective action as appropriate. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:* Re-education was provided to all staff on the Physical Restraint Policy including appropriate positioning to ensure resident movements are not restricted. IDT/designee will utilize the Facility Leadership Safety/Positioning Rounding Tool daily x 1 week, then weekly x 4 weeks, and then monthly x 3 months. Any concerns during rounds may initiate additional corrective action as appropriate. *How the corrective action will be monitored to ensure the deficient practice will not recur:* To ensure compliance, the DNS/ designee is responsible for the	

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	2 indicated severe cognitive impairment. Section P: Restraints and Alarms indicated there was no use of restraints or alarms at time of assessment. A policy was received on 4/28/23 at 2:03PM from DON (Director of Nursing) titled, "Physical Restraint Policy" original date of 6/2013 and last revision date of 11/2017. The policy stated " ...to ensure residents are free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. If a physical restraint is used, the facility must use the least restrictive restraint for the least amount of time. Provide ongoing evaluation of the need for the restraint .....Examples of facility practices that meet the definition of starting include, but not limited to: ...Placing a chair or bed close enough to a wall that the resident is prevented from rising out of chair or voluntarily getting out of bed ...procedure: 4. A physician's order will be obtained and will include the type, duration, frequency, and the medical condition or symptom (s) warranting the device use. 6. The resident or family member will sign the restrictive device notification form at the next visit or verbal consent may be obtained. 7. A restraint release record will be initiated to document that the resident is checked every hour ...8. The care plan will be updated to include the reason for restraint use and reduction plans. The care plan must focus on preventing adverse effects of restrictive device use ...." 3.1-3(w)		completion of the Physical Restraint QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as indicated. *What date the systemic changes for each deficiency will be completed:* All audits and systemic changes will be fully implemented by May 24, 2023.	
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan			

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to ensure care plans were developed and implemented for 2 of 2 residents reviewed with communication deficit. (Resident 68 and Resident 21). Finding include: 1) Resident 68's record was reviewed on 04/28/23 9:39 AM. Diagnoses included cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia - oropharyngeal phase - following cerebral infarction, and encephalopathy. Resident 68's quarterly Minimum Data Set (MDS) assessment, dated 3/3/23, indicated the resident's Brief Interview for Mental Status (BIMS) score was 11, he was confused and not interviewable. The MDS assessment indicated he had unclear speech and could be usually understood. The resident experienced shortness of breath when laying flat and was on oxygen therapy while a resident at the facility. Resident 68's admission MDS assessment, dated 11/18/22, indicated the Care Area Assessment (CAA) Summary triggered a care area of cognitive loss for care planning decisions. There was no indication Communication deficit was considered	F 0656	F656 Development/Implement Comprehensive Care Plan *What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Care Plans related to communication/cognitive deficits have been updatedd and completed for resident #68 and resident #21. No adverse effects were noted related to the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* All residents with cognitive/communication deficits have the potential to be affected by the alleged deficient practice. An audit was completed on 5/22/23 by Regional Social Wellness Consultant and care plans r/t cognitive/communication deficits were implemented as indicated. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*	05/24/2023

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	in this area. During an interview on 4/26/23 at 9:28 AM, Resident 68's speech was slurred, garbled, and could not be understood approximately 90% of the time. During an interview on 4/28/23, the Director of Therapy indicated Resident 68 had been in speech therapy off and on since November 2022. She indicated recently, therapy began 2/13/23. She indicated staff should use simple questions with yes or no answers to communicate with the resident. Resident 68's current care plan, dated 4/26/23, was reviewed. There was no care plan for the resident's cognitive loss (provided the problem, a goal, and actions for staff to do to help the resident reach his full ability) or to address the resident's communication deficit. 2) Resident 21's record was reviewed on 04/28/23 at 2:47 PM. Diagnoses included cognitive communication deficit, Parkinson's disease, disorientation, and hallucinations. Resident 21's comprehensive MDS assessment, dated 3/22/23, indicated the resident's BIMS score was 6. He was not interviewable. The MDS assessment indicated he had clear speech and could be understood. The MDS assessment indicated he had diabetes mellitus. The Care Area Assessment (CAA) Summary triggered the care area of cognitive loss for care planning decisions. There was no indication Communication deficit was considered in this area. During an interview on 4/26/23 at 9:50 AM, Resident 21 was pounding on the wall and did not		Re-education was provided to the IDT team by Regional Director of Clinical Services on developing and implementing a comprehensive person-centered care plan for each resident including cognition/communication. All care plans will be reviewed at minimum with admission, quarterly, and significant changes and updated as indicated. *How the corrective action will be monitored to ensure the deficient practice will not recur:* To ensure compliance, the DNS/ designee is responsible for the completion of the Comprehensive Care Plan Review QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as indicated. *What date the systemic changes for each deficiency will be completed: May 24, 2023* All audits and systemic changes will be fully implemented by May 24, 2023	

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	respond to questions. During an interview on 4/28/23 at 2:52 PM, RN 4 indicated Resident 21 answered simple questions with a yes or no. Resident 21's current care plan, dated 4/26/23, was reviewed. There was no care plan to address the resident's communication deficit. In an interview with the Regional Nurse Consultant (RNC) 3 on 4/28/23 at 12:40 PM, she indicated she could not locate a care plan for cognitive loss for Resident 68 or Resident 21. She indicated both residents had a diagnosis of cognitive communication deficit and should had had a cognitive loss care plan. On 5/3/23 at 10:40 AM, policy titled "IDT Comprehensive Care Plan Policy", dated reviewed 10/2019, provided by RN 2, indicated the comprehensive care plan was to be person-centered and based on the resident assessment to promote their highest level of functioning including medical, nursing, mental, and psychosocial needs. The care plan was to be reviewed on a regular basis about the resident's goals, total health status, including functional status, rehabilitation and restorative status, physical impairments and should include care and services to maintain and restore health and well-being, improve functional level, and relieve symptoms.			