STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. BUILDING 00 B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 29, 30, 31 and April 3 and 4, 2023 Facility number: 001152 Provider number: 155658 AIM number: 200221050 Census Bed Type: SNF/NF: 88 Residential: 75 Total: 163 Census Payor Type: Medicare: 9 Medicaid: 68 Other: 11 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 11, 2023.	F 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on May 17, 2023.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident had	F 0554	It is the policy of Wesley Manor to only allow a resident to	05/17/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary "BRENT" Waymire	Executive Director / Administrator	04/27/2023

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	been assessed for self-administration of medications before leaving medications unattended with a resident for 1 of 1 resident randomly reviewed for self-administration of medications. (Resident 45) Finding includes: During a random observation, on 03/30/23 at 9:28 a.m., a medication cup containing 11 pills was found on Resident 45's breakfast tray, on the bedside table, in the resident's room. The resident was in the restroom, her roommate was up in a recliner in the room, and there were no staff present. The record for Resident 45 was reviewed on 03/30/23 at 9:31 a.m. Diagnoses included, but were not limited to, chronic pain, type 2 diabetes, and atrial fibrillation. A self-administration of medication assessment was not found in the record. An order to self-administer medications was not found in the record. During an interview, on 03/30/23 at 9:31 a.m., LPN 5 indicated she left the medications in the room unattended. The resident usually took the medications when she got up, but she went to the restroom first. LPN 5 indicated she was not supposed to leave the medications with the residents, the resident needed to have an assessment to self-administer and an order to self-administer medications. During an interview, on 03/30/23 at 12:40 a.m., the Director of Nursing indicated the facility did not have an assessment to self-administer		self-administer medications if the interdisciplinary team has determined that the practice is clinically appropriate, and a physician's order is obtained. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The medications for resident 45 were removed and reviewed for accuracy to the Medication Administration Record, (MAR) and re-administered by a Nurse. LPN 5 was re-educated on the policy and procedure regarding self-administration of medications. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on April 19, 2023, for any resident who might self-administer medications. One resident was found to have nasal spray at bedside. A self-administration of medication was completed, and the resident deemed appropriate to self-administer the medication and a physician's order to do so was obtained. The self-administration assessment has been scheduled quarterly or as needed with a condition change. The audit found no other residents affected. What measures will be put into place or systematic changes made to ensure that the alleged	

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	medications for Resident 45. A current policy, titled "Medication: Self-Administration and Bedside Storage," last revised on June 01, 2011, and received from the Assistant Executive Director on 03/30/23 at 12:40 p.m., indicated "...Residents who request to self-administer drugs will be assessed to determine if the practice is safe...." 3.1-11(a)		deficient practice will not recur? Wesley Manor's policy and procedure regarding ***"Medication: Self-Administration and Bedside Storage"*** was updated with a revision effective date of April 25, 2023. The Wesley Manor ***"New Admission or Re-Admission"*** checklist was also revised as of April 23, 2023, to include item #37. Order and assessment completed for any self-administered medications/treatments. A Nursing Meeting was held on April 25, 2023, which covered the following topics: Self-administration of medication, PASARR, Medication Storage, Antibiotic Stewardship and Resident Service Plans. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random medication administration observation reviews, the nursing leadership team, (Director of Nursing, Memory Care Unit Manager, MDS Coordinator and In-Service/Education Coordinator), will monitor that medications are not left with residents for self-administration, who have not been deemed by the interdisciplinary team to do so, and a physician's order is not present to do so. The results of the New Admission	

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			or Re-Admission checklist audits for the previous week will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure PASARR (preadmission screening and resident review) were completed when a new mental health diagnoses and a new antipsychotic medication were added for 2 of 2 residents	F 0644	It is the policy of Wesley Manor to coordinate assessments with the pre-admission screening and resident review (PASARR) program.	05/17/2023

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	reviewed for PASARR. (Resident 73 and 70) Findings include: 1. The record for Resident 73 was reviewed on 3/31/23 at 4:19 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and dementia with agitation. A PASARR level I, dated 10/7/22, indicated the resident's mental health conditions were major depression and anxiety disorder. The Level I screen indicated a PASARR disability was not present. If a status change occurred or other information suggested a potential serious mental illness, then an updated Level I must be submitted to report the change to reevaluate the need for a PASARR level II behavioral health evaluation. The PASARR Level I did not include an unspecified psychosis not due to a substance or known physiological condition. During an interview, on 4/4/23 at 11:25 a.m., the Associate Executive Director indicated a new PASARR should have been completed with the addition of the diagnosis of unspecified psychosis not due to a substance or known physiological condition.2. The record for Resident 70 was reviewed on 3/31/23 at 2:12 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance and mood disturbance, anxiety disorder, and depression. A PASARR level II, dated 2/7/23, indicated the resident's mental health conditions were dementia		*How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The PASARR Level I was updated on April 3, 2023, for resident 73 to include the addition of the diagnosis of unspecified psychosis not due to a substance or known physiological condition. The PASARR Level I was updated on April 3, 2023, for resident 70 to include the ordered medication Risperdal Oral Tablet 0.5 mg. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on April 25, 2023, pulling PASARR data from the MAXIMUS system to confirm which residents require an update. For those residents where an update was identified, the PASARR system will be updated on or before May 17, 2023. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor's policy and procedure regarding ***"Social Services"*** was updated with a revision effective date of April 25, 2023, to delineate that the responsibility to update the PASARR with diagnosis and medication changes falls under Social Services.	

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	and anxiety disorder. The Level II screen indicated a PASARR disability was not present. If a status change occurred or other information suggested a potential serious mental illness, then an updated Level I must be submitted to report the change to reevaluate the need for a PASARR level II behavioral health evaluation. A physician's order, dated 3/21/23, indicated Risperdal (an antipsychotic medication) 0.5 mg (milligram) 1 tablet at bedtime. A new PASARR level I was not completed when Resident 70 was ordered Risperdal Oral Tablet 0.5 mg. During an interview, on 4/4/23 at 4:52 p.m., the Associate Executive Director indicated the resident most likely did not have a new PASARR completed when Risperdal was added. A new PASARR level I should have been completed. The facility did not have a PASARR policy. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The Social Service staff, during the Behavior portion of the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday, utilizing the Behavior Weekly Tracking form, residents with medication and/or diagnosis changes will be reviewed and determined if this meets the criteria for a PASARR update. The results of the Behavior Weekly Tracking checklist audits for the previous week regarding medication and/or diagnosis changes necessitating a PASARR update will be reported in the Behavior portion of the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to label and date medications for 2 of 4 medication carts reviewed during medication storage. (G wing and H wing medication carts) Findings include: 1. During an observation, on 03/29/23 at 2:48 p.m., the 2nd floor "G" wing medication cart A was observed with Licensed Practical Nurse (LPN) 2. Observed in the top drawer was: a) Basaglar (brand name insulin) insulin pen with no open date on the used insulin. b) Lispro (band name insulin) insulin pen with no open date on the used insulin. c) Toujeo (brand name insulin) insulin pen with no open date on the insulin. d) Aspart (brand name insulin) insulin pen with no open date.	F 0761	It is the policy of Wesley Manor to assure drugs and biologicals used must be labelled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and expiration date when applicable. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The “G” wing medication cart A observed with the following insulin pens with no open date on the used insulin: a) Basaglar, b) Lispro, c) Toujeo, and d) Aspart, were all discarded and re-ordered. The “H” wing medication cart B observed with the following insulin	05/17/2023

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	During an interview, on 03/29/23 at 2:48 p.m., LPN 2 indicated none of the insulin pens observed in "G" wing medication cart A had open dates on the insulin pens. 2. During an observation, on 03/29/23 at 3:24 p.m., the 2nd floor "H" wing medication cart B was observed with LPN 3, and in the top drawer was a Levemir (brand name insulin) insulin pen with no open date on the pen or package. During an interview, on 03/29/23 at 3:24 p.m., LPN 3 indicated the insulin pen observed in the "H" wing medication cart B did not have an open date on the insulin. During an interview, on 03/30/23 at 2:19 p.m., the Director of Nursing (DON) indicated staff were to label all insulin pens with a date first used. A current policy, titled "Vials and Ampules of Injectable Medications," dated as last reviewed on 05/2016 and received from the Assistant Associate Director on 3/30/23 at 2:49 p.m., indicated "...Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations...and vials and ampules will have...The date opened and the initials of the first person to use the vial are recorded on multidose vials on an accessory label affixed for that purpose...." 3.1-25(k)(6)		pens with no open date on the used insulin Levemir, was discarded and re-ordered. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on April 19, 2023, of each of the medication carts to verify if insulin pens were dated when opened, (dating the bag that the insulin pen is kept in). The audit found no other residents affected. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? A Nursing Meeting was held on April 25, 2023, which covered the following topics: Self-administration of medication, PASARR, Medication Storage, Antibiotic Stewardship and Resident Service Plans. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The Charge Nurses will be responsible to conduct a Med Cart Weekly Audit on the 10:00 PM – 6:00 AM shift to include but not limited to verifying that insulin pens are dated when opened. These audits are turned in to the Director of Nursing for follow-up and corrective action as necessary.	

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			Through routine and random medication cart reviews, the nursing leadership team, (Director of Nursing, Memory Care Unit Manager, MDS Coordinator and In-Service/Education Coordinator), will monitor that insulin pens are dated when opened. The results of the Med Cart Weekly audits for the previous week will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store food, and wash and dry dishes in a sanitary manner resulting in the potential for all residents who consume food from the kitchen to become ill from food borne illness. Findings include: During a kitchen tour, on 03/30/23 at 10:00 a.m., with the Director of Dining Services (DDS) the following was observed: 1. The clean and dry storage rack was observed to have: a) A small metal tong with a brown particle on the tong. b) A metal 1/2 (half) cup with a brown substance on the inside of the cup. c) A large sheet pan with a clear liquid in inside of the pan. d) A 2-inch side pan with a yellow substance scattered throughout the inside of the pan. e) A 2-inch pan with a clear liquid in the bottom of the pan and a light gray substance on the bottom of pan. f) A pizza cutter was noted with brown bits on the blade. 2. The walk-in cooler was observed to have: a) An open carton of heavy whipping cream with the top open to air (not re-sealed after opening). b) A 4-inch pan of white whipped potatoes was observed, and the pan was warm to the touch.	F 0812	It is the policy of Wesley Manor to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The following was done immediately during, or following the tour of the kitchen: 1.a) The small metal tong was re-washed, 1.b) The metal ½ cup was re-washed, 1.c) The large sheet pan was re-washed, 1.d) The 2-inch side pan was re-washed, 1.e) The 2-inch pan was re-washed, 1.f) The pizza cutter was re-washed. 2.a) The heavy whipping cream was discarded, 2.b) The white whipped potatoes were discarded. 3. The plastic container of cut carrots was discarded. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on March 30, 2023, by the Dining Services Director and no other issues were found in the kitchen. What measures will be put into	05/17/2023

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	3. In the walk-in freezer, an open plastic container of cut carrots was noted with ice crystals on the frozen carrots. During an interview, on 03/30/23 at 10:10 a.m., the DDS indicated there was debris and liquid on the cooking utensils and pans and they needed to be rewashed and dried because the dishware was not clean. The open whipping cream should have been covered in plastic, frozen carrots needed to be covered and a cooling was necessary for the mashed potatoes. During an interview, on 03/30/23 at 10:19 a.m., the Kitchen Supervisor (KS) 4 indicated there was no cooling log for the mashed potatoes in the walk-in cooler. A current policy, titled "Sanitation and Infection Prevention/Control," dated as last reviewed on 01/2023 and received from the DDS on 3/30/23 at 12:17 p.m., indicated "...Pots, dishes, and flatware are stored in such a way as to prevent contamination by splash, dust, pests, or other means...air dry all food contact surfaces, including pots, dishes, flatware and utensils before storage...." A current policy, titled "Food Handling Guidelines," dated as last reviewed on 12/2009 and received from the DDS on 3/30/23 at 12:17 p.m., indicated "...Cooling of potentially hazardous cooked foods: Food shall be cooled...Use the Cooling Log form at the end of this policy to document the temperature of the food...." 3.1-21(i)(3)		place or systematic changes made to ensure that the alleged deficient practice will not recur? The Director of Dining Services conducted an in-service with dining staff on April 25, 2023, to cover the following topics: Proper Storage of Pots/Pans/Utensils, Proper Food Storage / Handling, Proper Cleaning of Food and Non-Food Contact Surfaces, and the required use of hair restraints, (hair nets), in the kitchen. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? A Dining Services Manager or Supervisor will be responsible to conduct a “Quick Pulse Food Safety Sanitation Audit” once per shift through May 17, 2017. These audits are turned in to the Director of Dining Services for follow-up and corrective action as necessary. The Dining Services Manager, Assistant Dining Services Manager, or the Registered Dietitian will be responsible to conduct a more in-depth “Infection Control Focused Audit” weekly for the next three months. The results of the Quick Pulse Food Safety Sanitation Audit and the Infection Control Focused Audit for the previous week will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and	

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			reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure the prophylactic antibiotic was reviewed and monitored for 1 of 1 resident reviewed for antibiotic use. (Resident 43) Finding includes: The record for Resident 43 was reviewed on 03/31/23 at 10:02 a.m. Diagnoses included, but were not limited to, urinary tract infections. A physician's order, dated 1/26/23, indicated cephalexin (an antibiotic) 250 mg (milligrams) daily as a prophylactic medication. A progress note, dated 2/27/23 at 4:17 p.m., indicated the hospice nurse was in the facility and the Foley catheter was changed with a 16 French 10 ml (milliliter) bulb. The resident's prophylactic antibiotic was reordered from the pharmacy. The hospice nurse was aware of the antibiotic issue.	F 0881	It is the policy of Wesley Manor to have an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* Monitoring for side effects for the prophylactic antibiotic and the McGeer Criteria completed for resident 43. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on April 19, 2023, for any resident on a prophylactic antibiotic that did not include review and monitoring.	05/17/2023

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	155658	A. BUILDING 00 B. WING	04/04/2023

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	A progress note, dated 2/27/23 at 4:24 p.m., indicated the hospice nurse called the facility nurse and gave a verbal order for Macrobid (an antibiotic) 100 mg twice a day for ten days then to resume the Keflex (cephalexin) order due to dark urine color was noted with sediment. A surveillance log reviewed on 04/03/23 at 4:26 p.m., indicated the prophylactic antibiotic was not listed to be monitored. During an interview, on 4/3/23 at 3:37 p.m., the Infection Preventionist indicated the facility was not monitoring the prophylactic cephalexin. During an interview, on 4/3/23 at 3:45 p.m., the Director of Nursing indicated the resident was admitted to the facility with the prophylactic dose of cephalexin due to a history of multiple urinary tract infections. There was no surveillance for the prophylactic cephalexin. She was not aware of alternatives tried prior to the prophylactic cephalexin. A current policy, titled "Antibiotic Stewardship," dated 2/27/20 and received from the Administrator on 4/4/23 at 4:30 p.m., indicated "...The purpose of the program is to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events. Antibiotic Stewardship is a part of our Infection Control Program. The facility will track antibiotic use daily. The facility will communicate with the physicians(s) prescribing antibiotics with an "Antibiotic Report Card" on a monthly basis and as needed...The facility will ensure the pharmacy reviews all antibiotic usage for appropriateness. Antibiotics use will be calculated on a monthly basis for QAPI purposes. The facility will monitor for all adverse		Four residents were identified with the McGeer Criteria completed and review and monitoring commencing with each resident. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor's policy and procedure regarding ***"Antibiotic Stewardship"*** was updated with a revision effective date of April 25, 2023. The Wesley Manor ***"New Admission or Re-Admission"*** checklist was also revised as of April 23, 2023, to include item #36. Order for any prophylactic ATB – McGeer attached with order to do monthly S/E monitor. A Nursing Meeting was held on April 25, 2023, which covered the following topics: Self-administration of medication, PASARR, Medication Storage, Antibiotic Stewardship and Resident Service Plans. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random prophylactic antibiotic medication reviews, the nursing leadership team, (Director of Nursing, Memory Care Unit Manager, MDS Coordinator and In-Service/Education Coordinator), will monitor that prophylactic antibiotics include review and monitoring for side effects.	

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	reactions/outcomes related to antibiotic therapy...." 3.1-18(b)(1)(A)		The results of the New Admission or Re-Admission checklist audits for the previous week will be reported in the Infection Control portion of the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 29, 30, 31 and April 3 and 4, 2023 Facility number: 001152 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 11, 2023.	R 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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			Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on May 17, 2023.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident service plans were signed	R 0217	It is the policy of Wesley Manor to assure that the agreed upon	05/17/2023

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	and dated for 5 out of 5 records reviewed for service plans. (Resident 1, 2, 3, 4, 5) Findings include: 1. The record for Resident 1 was reviewed on 03/30/2023 at 8:32 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, gastro-esophageal reflux disease, and osteoarthritis. The current service plan lacked Resident 1's signature and date of the review. 2. The record for Resident 2 was reviewed on 03/30/2023 at 8:41 a.m. Diagnoses included, but were not limited to, atherosclerosis, monoclonal gammopathy, cardiac pacemaker, hypertension, epilepsy, and major depressive disorder. The current service plan lacked Resident 2's signature and date of the review. 3. The record for Resident 3 was reviewed on 03/30/2023 at 9:02 a.m. Diagnoses included, but were not limited to, hypertension, benign prostatic hyperplasia (enlargement of prostate), gastro-esophageal reflux disease, and chronic serous otitis media (middle ear infection). The current service plan lacked Resident 3's signature and date of the review. 4. The record for Resident 4 was reviewed on 03/30/2023 at 9:21 a.m. Diagnoses included, but were not limited to, hypertension, and rheumatoid arthritis. The current service plan lacked Resident 4's signature and date of the review.		service plan is signed and dated by the resident and a copy of the service plan is given to the resident upon request. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The Service Plans for residents 1, 2, 3, 4, and 5, were reviewed with the residents and the resident was offered the option of signing and dating the Service Plan electronically, or hard copy. A copy was provided to the resident if desired. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on April 25, 2023, for any resident whose most recent Service Plan was not signed and dated. If identified, the resident was offered the option of signing and dating the Service Plan electronically, or hard copy. A copy was provided to the resident if desired. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor's policy and procedure regarding ***"Service Plans"*** was updated with a revision effective date of April 25, 2023. A Nursing Meeting was held on April 25, 2023, which covered the	

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	5. The record for Resident 5 was reviewed on 03/30/2023 at 9:43 a.m. Diagnoses included, but were not limited to, depressive episodes, hypothyroidism, gastro-esophageal reflux disease, bladder disorder, paroxysmal atrial fibrillation, bladder disorder, and bilateral artificial hip joint. The current service plan lacked Resident 5's signature and date of the review. During an interview, on 03/30/2023 at 3:12 p.m., RN 1 indicated the service plans were reviewed with the residents however she was unaware residents needed to sign and date the plan when reviewed. A current policy, titled "Service Plan," dated as last updated 2013 and received on 04/04/2023 at 10:41 a.m., indicated " ...2. The plan will be reviewed with the resident during reviews of the resident's needs, at least every 6 months...4. A copy of the plan will be provided to the resident, their responsible party, and Case Manager if applicable...."		following topics: Self-administration of medication, PASARR, Medication Storage, Antibiotic Stewardship and Resident Service Plans. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random Service Plan audits, the Resident Services Director will audit Service Plans to verify that they are being signed and dated by the resident, either electronically or hard copy and that if the resident desires copy of the Service Plan, that it was provided. The results of the Service Plan audits for the previous week will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to serve food in accordance with	R 0273	It is the policy of Wesley Manor to all food preparation and serving	05/17/2023

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	professional standards for food service safety when 2 kitchen staff failed to wear a hair restraint which completely covered their hair while in the kitchen and food preparation area. (Kitchen Employee 3 and 4) Findings include: 1. On 03/31/2023 at 10:53 a.m., Kitchen Employee 3 was observed to come from the interior of the kitchen to the entrance door without a hair restraint. The employee indicated she would find the Dietary Manager (DM) to assist with the kitchen tour and disappeared back into the interior of the kitchen, out of sight. When Employee 3 returned, she still did not have a hair restraint. Employee 3 indicated where the hair restraints were located and was observed to place one over her hair at that time. 2. On 03/31/2023 at 10:58 a.m., Kitchen Employee 4 was observed in the food preparation area of the kitchen without hair restraint. Employee 4 indicated he would get a hair restraint and disappeared into the kitchen, returning with a hair restraint. A current policy, titled "Dress guidelines for food service management and clinical nutritional staff," dated as last revised January 2020, and received from the Dietary Manager on 04/04/2023 at 10:11 a.m., indicated "...Hair restraints are worn by all when in the kitchen. This includes department associates, associates from other facility departments and guests, such as vendors..."		areas are maintained in accordance with state and local sanitation and safe food handling standards, including wearing a hair restraint which completely covers their hair while in the kitchen and food preparation area. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* Staff put on a hair restraint to participate in the tour of the kitchen with the surveyor. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on March 30, 2023, by the Dining Services Director and no other staff members were identified without the proper hair restraint in the kitchen. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? The Director of Dining Services conducted an in-service with dining staff on April 25, 2023, to cover the following topics: Proper Storage of Pots/Pans/Utensils, Proper Food Storage / Handling, Proper Cleaning of Food and Non-Food Contact Surfaces, and the required use of hair restraints, (hair nets), in the kitchen. How will the facility monitor its corrective actions to ensure that	

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			the alleged deficient practice will not recur? A Dining Services Manager or Supervisor will be responsible to conduct a “Quick Pulse Food Safety Sanitation Audit” once per shift through May 17, 2017. These audits are turned in to the Director of Dining Services for follow-up and corrective action as necessary. The Dining Services Manager, Assistant Dining Services Manager, or the Registered Dietitian will be responsible to conduct a more in-depth “Infection Control Focused Audit” weekly for the next three months. The results of the Quick Pulse Food Safety Sanitation Audit and the Infection Control Focused Audit for the previous week will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) held each Thursday for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	