STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF CHESTERTON LLC	2775 VILLAGE POINT CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and included the Investigation of Complaints IN00380144 and IN00381235. This visit included a State Residential Licensure Survey. Complaint IN00380144 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00381235 - Unsubstantiated due to lack of evidence. Survey dates: August 11, 12, 15, 16, 17, and 18, 2022. Facility number: 013688 Provider number: 155844 AIM number: 201352370 Census Bed Type: SNF/NF: 9 SNF: 60 Residential: 33 Total: 102 Census Payor Type: Medicare: 41 Medicaid: 9 Other: 19 Total: 69 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/23/22.	F 0000	**Symphony of Chesterton Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** Symphony of Chesterton Kindly requests a desk review	

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

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents were provided assistance with activities of daily living (ADL's) related to assistance with eating and showers for 2 of 5 residents reviewed for ADL's. (Residents 30 and 177) Findings include: 1. On 8/15/22 at 9:30 a.m., Resident 30 was sitting upright in bed. Her breakfast meal was in front of her on the over bed table. She was observed staring at the food and moaning out loud. She was not eating any of her food. She was served sausage links which were cut up, scrambled eggs, hash browns and hot cereal. There were no staff in the room to assist the resident. The resident was in droplet/contact isolation for being COVID-19 positive. On 8/16/22 at 9:01 a.m., the resident was observed sitting upright in bed. Her breakfast meal was in front of her on the over bed table. She was observed fumbling with her napkin and was not eating any of her food. She was served toast which was cut in half, scrambled eggs, hash browns, and a strip of sausage that was not cut up into pieces. There were no staff in the room to assist the resident. Interview with CNA 1 on 8/16/22 at 9:17 a.m., indicated the breakfast trays arrived to the unit around 8:30 a.m. that morning.	F 0677	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F677 ADL'S-** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #30 assistance provided with eating. New assessment of feeding abilities completed. New order obtained from physician for self-feed. Resident had no ill effect due to alleged deficient practice. · Resident #177 Shower preference reviewed with family/resident. Shower preference adjusted and care plan updated to reflect preference. Resident had no ill effect due to alleged deficient practice.	09/07/2022

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	The record for Resident 30 was reviewed on 8/15/22 at 11:30 a.m. The resident was admitted on 7/4/22. Diagnoses included, but were not limited to, dementia without behaviors, major depressive disorder, psychotic disorder with hallucinations, chronic kidney disease, high blood pressure, and osteoporosis. The Admission Minimum Data Set (MDS) assessment, dated 7/11/22, indicated the resident was not alert and oriented and she needed supervision with one person physical help with eating. She had no oral problems, weight loss, and was not on a special diet. A Care Plan, dated 7/5/22, indicated the resident had a regular diet. The approaches were to assist with feeding as needed. Physician's Orders, dated 7/4/22, indicated regular diet and texture. Feed assist when the family was not present. The resident weighed 122 pounds on 7/10/22 and 114 pounds on 8/1/22, which was a 6.56% weight loss. Interview with the Director of Nursing on 8/17/22 at 8:45 a.m., indicated in the past the resident would refuse for staff to help her eat. 2. During a family interview with Resident 177's son on 8/11/22 at 10:53 a.m., indicated he had concerns with her getting bathed and her hair washed. The record for Resident 177 was reviewed on 8/15/22 at 1:40 p.m. The resident was admitted on 7/28/22. Diagnoses included, but were not limited		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current residents needing feeding assistance have the potential to be affected by this alleged deficient practice. Audit completed of all residents in house that need assistance with feeding to ensure proper assistance given. · All residents requiring assistance with showers have the potential to be affected by this alleged deficient practice. Audit completed of all resident's shower preference in house and care plans updated accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Clinical staff were educated on aiding residents that require feeding assist · Clinical staff were educated on assisting and giving preferred method of shower. · Director of nursing/designee will audit 5 residents per week to ensure	

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	to, stroke, hemiplegia, aphasia, muscle weakness, high blood pressure, osteoarthritis, and urinary incontinence. The Admission Minimum Data Set (MDS) assessment, dated 7/30/22, indicated the resident had long term memory problems and was not able to recall her room, staff names, and the current season. The resident was totally dependent on staff for bathing. A Care Plan, dated 8/10/22, indicated the resident's preference was to shower. A Care Plan, dated 7/29/22, indicated the resident had a self care deficit with ADL's related to stroke. The showers were scheduled every Tuesday and Friday on the day shift. The resident had received 1 shower since admission on 8/12/22 and a complete bed bath on 7/29/22 and 8/5/22. There was no documentation the resident had refused bathing. Interview with the Director of Nursing on 8/17/22 at 8:45 a.m., indicated residents were to receive two showers per week. 3.1-38(a)(2)(D) 3.1-38(b)(2)		proper meal assistance is provided to residents who require feeding assist. · Director of nursing/designee will audit 5 residents per week to ensure proper showering preference is provided. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect proper feeding assist and shower preference is provided weekly using attached audit sheet. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 6 residents reviewed for unnecessary medications. The facility also failed to ensure TED hose and/or tubi grips (anti-embolism/compression stockings) were applied as ordered for 1 of 3 residents reviewed for skin conditions (non-pressure related). (Residents 114 and 165) Findings include: 1. On 8/11/22 at 2:09 p.m., Resident 114 was observed with fading areas of bruising to her right hand and the left and right antecubital area (the area located near the crook of the elbow) on both arms. Interview with the resident at that time, indicated the bruises were from, "lab sticks." The record for Resident 114 was reviewed on 8/15/22 at 2:50 p.m. Diagnoses included, but were not limited to, history of stroke and history of venous thrombosis and embolism (blood clots). The Admission Minimum Data Set (MDS) assessment, dated 8/11/22, indicated the resident was cognitively intact and she needed extensive assistance with bed mobility and transfers. The resident had received an anticoagulant (blood thinner) within the past 7 days.	F 0684	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F684 Quality of Care-** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 165 had updated orders with Tubi Grip applied as guest will allow. Resident was here for rehab and discharged from facility on 8/16/2022 with home health care of their preference. · Resident 114 had full head to toe skin assessment completed and updated monitoring orders placed for right hand and bilateral arms.	09/07/2022

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	The Care Plan, dated 8/10/22, indicated the resident was on anticoagulant/Aspirin therapy related to cardiac disease. Interventions included, but were not limited to, monitor/document/report to Physician as needed for signs and symptoms of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath (SOB), loss of appetite, bleeding of the gums, sudden changes in mental status, and significant or sudden changes in vital signs. A Physician's Order, dated 8/5/22, indicated the resident received Apixaban (a blood thinner) 5 milligrams (mg) two times a day related to personal history of venous thrombosis and embolism. Wound Care Notes, dated 8/10/22 at 2:20 p.m., indicated scattered bruising continued. There was no documentation of where the areas of bruising were located. There were no orders to monitor the bruising to the resident's right hand and bilateral arms. The resident had blood work drawn on 8/5/22, 8/8/22, and 8/15/22. Nurses' Notes, dated 8/17/22 at 12:40 p.m., indicated during a head to toe assessment, bruising was observed to the left and right arm. Scattered purple/green bruising was observed from lab draws per the resident. The left arm measured 30 centimeters (cm) x 10 cm and the right arm measured 35 cm x 8 cm. Will continue to follow weekly for healing and as needed. Physician updated.		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents have the potential to be affected by this alleged deficient practice. In house audit completed for Ted hose orders and verified for placement. · In house skin sweep was performed to ensure all orders were in place and updated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on the assessment and order entry for proper monitoring and documentation of skin issues and Ted hose in place. · Director of nursing/designee will randomly audit five residents each week for proper skin monitoring orders for change in skin condition, documentation, and timely assessment. · Director of nursing/designee will randomly audit five residents each week for	

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	A Physician's Order, dated 8/17/22, indicated to monitor scattered bruising to the left arm, right arm, and right breast until resolved every shift for skin check. Interview with the Director of Nursing on 8/17/22 at 2:30 p.m., indicated the bruising to the resident's hand and arms should have been monitored. 2. During an interview with Resident 165 on 8/11/22 at 11:45 a.m., she indicated both of her feet were very swollen and they were not like that in the hospital. She also indicated there was a blistered area to the left outer leg and the doctor told her she was supposed to have wraps for both of her legs, but had not had them since she had been there. On 8/15/22 at 9:30 a.m. and 11:20 a.m., the resident was up and dressed sitting in her wheelchair. She was wearing a pair of anti-skid socks to both feet. There was a bandage on her left leg. She was not wearing any TED hose (a compression stocking) or tubi grips (a tubular elastic bandage designed to provide tissue support and compression in the treatment of conditions such as edema, soft tissue injuries, and weak joints) to either leg. The record for Resident 165 was reviewed on 8/15/22 at 9:40 a.m. The resident was admitted to the facility on 7/31/22. Diagnoses included, but were not limited to, high blood pressure, anemia, osteoarthritis, and acute kidney failure. The Admission Minimum Data Set (MDS) assessment, dated 8/7/22, indicated the resident was alert and oriented and had no open areas, no foot infections, and no skin problems. A Care Plan, dated 8/15/22, indicated the resident		new orders related to Ted hose or Tubi grips. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect proper skin monitoring orders for change in skin condition, documentation, and timely assessments occur weekly. · Director of nursing/designee will complete audit tool each week for new orders related to Ted hose or Tubi grips. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	had bilateral lower extremity edema. The approaches were to elevate the affected extremities. A Nursing Admission Assessment, dated 7/31/22, indicated the resident had no edema, but had discolorations to bilateral feet and ankles. A Physician Progress Note, dated 8/8/22 at 12:35 p.m., indicated the resident complained of bilateral lower extremity edema. The assessment plan for the pedal edema indicated the edema was most likely secondary to venous stasis, and to elevate legs and to have TED hose during the daytime. A Wound Care Note, dated 8/11/22 at 1:40 p.m., indicated the resident had a clear fluid filled blister to the left lower leg. The resident's legs were edematous and the resident stated she had a wound in the past in this area and every so often when her legs were swollen she would get a blister. A Wound Care Note, dated 8/15/22 at 8:47 a.m., indicated the fluid filled blister was now ruptured. The wound bed was pale pink with moderate amount of drainage. Physician made aware of increased edema to legs. Physician's Orders, dated 8/15/22, indicated to cleanse left lower leg blister with 0.9% normal saline, pat dry, and apply xeroform (an occlusive wound dressing) to wound bed, cover with OptiLock (an absorbent wound dressing), ABD bandage (an absorbent wound dressing) and wrap with Kerlix (a bandage roll) daily and as needed (prn). Secure with tubi grip as guest will allow. Interview with RN 1 on 8/15/22 at 2:00 p.m., indicated there were no orders for TED hose in the			

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	resident's chart. She indicated if the Physician did not tell the nurse what they wanted ordered, she would not necessarily go back and read their progress notes. Interview with the Director of Nursing on 8/15/22 at 2:10 p.m., indicated the resident had a newly opened blister on the left leg and she would look into why the TED hose were not ordered. Continued interview with the Director of Nursing on 8/16/22 at 1:30 p.m., indicated the resident should have had a tubi grip to the left leg per the new treatment order on 8/15/22. 3.1-37(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting,			

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	dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure g-tube (gastrostomy tube, a tube inserted directly into the stomach) medications and flushes were instilled via gravity for 1 of 6 residents observed for medication administration. (Resident 119) Finding includes: On 8/16/22 at 11:54 a.m., RN 2 was observed preparing Resident 119's medications. She crushed each pill and placed it in a separate cup. She entered the resident's room and checked for placement of the g-tube with a stethoscope and air bolus. She obtained water from the faucet and filled each cup halfway with water. She also filled the flush bottle with water. She inserted the syringe into the flush bottle and drew up 30 cubic centimeters (cc) of water. She opened the g-tube and placed the syringe directly into the tube and pushed the water down the tube using the plunger. She removed the syringe, drew up the first cup of diluted medication, placed the syringe into the tube and pushed the medication down the tube using the plunger. She removed the syringe, drew up 30 cc of water from the flush bottle, placed the syringe into the tube and pushed the water down the tube using the plunger. She then removed the syringe, drew up the second cup of diluted medication, placed the syringe into the tube and pushed the medication down the tube using the plunger. She removed the syringe, drew up 30 cc of water from the flush bottle, placed the syringe into the tube and pushed the water down the tube using the plunger. She then closed the g-tube. She had not administered any of the medication or flushes via gravity.	F 0693	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F693 Tube Feed –** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #119 tolerated tube feeding without complications during stay. Guest discharged from facility on 8/18/22. · RN #2 immediately educated on proper tube feed administration. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents with enteric tube utilization have the potential to be affected by this alleged deficient practice. Audit completed to identify all residents with enteric	09/07/2022

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	The record for Resident 119 was reviewed on 8/17/22 at 10:57 a.m. Diagnoses included, but were not limited to, hypertension and gastrostomy status. The Admission Minimum Data Set (MDS) assessment, dated 8/6/22, indicated the resident was cognitively impaired, was dependent on enteral feedings, and received 51% or greater of all nutrition through the g-tube. Interview with the Director of Nursing on 8/17/22 at 8:53 a.m., indicated she would provide the current facility policy for g-tube medication administration. A facility policy, titled "Enteral Tube Medication Administration," indicated, "...16...Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube... 3.1-44(a)(2)		tubes. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on the process of enteral tube gravity administration process. · Director of nursing/Designee will identify 100% of residents with enteral tube feed. Director of nursing/designee will observe 2 enteral tube feed administrations for gravity process weekly. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect appropriate tube utilization process. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.	

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			Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was in place for a resident who received oxygen for 1 of 3 residents reviewed for oxygen. (Resident 4) Finding includes: On 8/12/22 at 9:37 a.m., Resident 4 was observed wearing oxygen via a nasal cannula with a flow rate of 2 liters. The resident indicated she always wore her oxygen. On 8/15/22 at 12:59 p.m., Resident 4 was observed wearing oxygen with a flow rate at 2 liters. Record review for Resident 4 was completed on 8/15/22 at 2:07 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, and anxiety disorder.	F 0695	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F695 Respiratory What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #4 oxygen order received from physician and placed in chart **How will you identify other residents having the potential to be affected by the**	09/07/2022

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	A Care Plan, initiated on 3/21/22, indicated the resident had oxygen therapy. Interventions included, but were not limited to, administer oxygen per orders. The record lacked any documentation of a Physician's Order for the use of oxygen. Interview with Director of Nursing on 8/15/22 at 2:25 p.m., indicated the resident did not have a Physician's Order for oxygen in place when she was observed wearing the oxygen, but should have had an order. 3.1-47(a)(6)		**same deficient practice and what corrective action will be taken.**· All current residents have the potential to be affected by this alleged deficient practice. All residents using oxygen were audited to ensure that oxygen order is in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· Facility nursing staff were educated on obtaining physician order for oxygen use for all patients in house. · Director of nursing/designee will audit 5 residents per week and ensure oxygen orders are appropriately placed in patient charts. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**· The Director of Nursing/designee will continue to randomly audit five residents to ensure proper oxygen order is in place using the attached audit sheet. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit	

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			will continue.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a dialysis perma cath was monitored and assessed daily for signs and symptoms of infection and bleeding for 1 of 1 residents reviewed for dialysis. (Resident 175) Finding includes: The record for Resident 175 was reviewed on 8/15/22 at 2:45 p.m. The resident was admitted to the facility on 7/22/22. Diagnoses included, but were not limited to, dependence on renal dialysis and end stage renal dialysis. The Admission Minimum Data Set (MDS) assessment, dated 7/29/22, indicated the resident was alert and oriented and received dialysis while a resident. The Care Plan, revised on 7/24/22, indicated the resident needed dialysis. The approaches were to monitor, document, and report to the doctor any signs and symptoms of infection to access site. The Care Plan, dated 7/31/22, indicated the resident had potential for complications related to right perma cath. The approaches were to check perma cath site daily and upon return from dialysis.	F 0698	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F698 Dialysis** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #175 monitoring perma cath daily completed no ill effects from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current residents on	09/07/2022

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	Physician's Orders, dated 7/22/22, indicated check perma cath site daily and upon return from dialysis. The 7/2022 and 8/2022 Medication Administration Records (MAR), indicated the perma cath assessment was only completed on dialysis days every Monday, Wednesday, and Friday. Interview with the Director of Nursing on 8/17/22 at 8:45 a.m., indicated the perma cath should have been assessed and checked on a daily basis, not just dialysis days. 3.1-37(a)		dialysis have the potential to be affected by this alleged deficient practice. · All residents receiving dialysis had their charts reviewed to ensure permcath monitoring was in place and completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on monitoring permcath sites daily. · Director of nursing/designee will randomly audit 100% of dialysis patients' charts 2x weekly to ensure daily permcath monitoring is completed **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect proper daily monitoring of permcath sites is completed for 100% of dialysis patients in house 2x weekly.	

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			· The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure an AIMS (Abnormal Involuntary Movement Scale) assessment was completed and psychotropic medication was not ordered prn (as needed) longer than 14 days for 2 of 5 residents reviewed for unnecessary medications. (Residents 20 and 10) Findings include: 1. The record for Resident 20 was reviewed on 8/16/22 at 10:15 a.m. The resident was admitted to the facility on 6/30/22. Diagnoses included, but were not limited to, delusions, insomnia, psychotic disorder, and dementia without behaviors.	F 0758	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F758 Free from Unnecessary Psychotropic Meds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	09/07/2022

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	The Admission Minimum Data Set (MDS) assessment, dated 7/6/22, indicated the resident was cognitively intact and had received an antipsychotic medication 7 times in the last 7 days. The antipsychotic medication was scheduled on a routine basis. A Care Plan, dated 7/3/22, indicated the resident used psychotropic medications related to delusional disorder and brief psychotic disorder. The approaches were complete an AIMS assessment quarterly and as needed. Physician's Orders, dated 6/30/22 indicated Seroquel (an antipsychotic medication) 25 milligrams (mg) every evening. Physician's Orders, dated 7/11/22, indicated Seroquel 25 mg, give 2 tablets by mouth in the evening. Physician's Orders, dated 7/14/22, indicated Seroquel 25 mg, give 3 tablets by mouth three times a day. The first and initial AIMS assessment was completed on 7/18/22. A Pharmacy recommendation, dated 7/12-7/15/22, indicated the resident had an order for Seroquel, recommend an AIMS assessment. Interview with the Director of Nursing (DON) on 8/17/22 at 8:45 a.m., indicated the AIMS assessment was not completed at the time of admission. The current and revised 11/2019 "Psychotropic Medications" policy, provided by the DON on 8/17/22 at 8:55 a.m., indicated a baseline AIMS		· Resident #10 PRN psychotropic medication order was updated with a 14-day stop date/ re-evaluation. No ill effects for resident #10. · Resident #20 AIMS assessment up to date and complete. No ill effects for resident #20. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents on psychotropic medications have the potential to be affected by this alleged deficient practice. Psychotropic medication review audit completed to ensure that all PRN psychotropic medication has a 14 day stop date. · All psychotropic medication will have an AIMS assessment completed on admission and every six months. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing staff educated on	

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	test may be done prior to starting any new psychotropic medication. After initiating a new drug the test will be repeated quarterly. 2. The record for Resident 10 was reviewed on 8/12/22 at 1:01 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, and psychotic disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 6/10/22, indicated the resident was severely cognitively impaired. The resident received an antipsychotic medication 5 times in the last 7 days. The antipsychotic medication was scheduled on a routine basis. A Care Plan, revised on 6/13/22, indicated the resident received an antipsychotic medication related to psychosis, major depressive disorder, insomnia, and anxiety. Interventions included, but were not limited to, administer medications as ordered. A Physician's Order, dated 7/24/22 at 5:30 p.m., indicated Seroquel (an antipsychotic medication) 25 milligram (mg) tablet every 8 hours as needed. The order had a start date of 7/24 and an end date of 8/11/22 which is 18 days. A Physician's Order, dated 8/11/22 at 11:30 a.m., indicated Seroquel (an antipsychotic medication) 25 milligram (mg) tablet every 8 hours as needed for 14 days. The record lacked documentation of a Physician assessment for the renewal of the antipsychotic medication. Interview with the Director of Nursing on 8/15/22 at 3:18 p.m., indicated the antipsychotic		AIMS assessment to be completed per policy for residents on psychotropic medication. · Nursing staff educated on a 14 day stop date for all PRN psychotropic medication. · Director of Nursing/Designee will audit five residents on psychotropic medications to ensure that AIMS/stop dates are completed. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will audit five residents on psychotropic medications utilizing the attached QA audit tool to ensure PRN psychotropic medication are discontinued at 14 days and AIMS assessments are completed. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit	

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	medication should have only been ordered "as needed" for a maximum of 14 days. A policy titled, "Psychotropic Medications," was received from the Director of Nursing on 8/17/22 at 8:55 a.m. This current policy indicated "...Guideline...7. If a resident has a PRN psychotropic medication order is should not exceed 14 days..." 3.1-48(a)(3) 3.1-48(b)(1)		will continue.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication administration. Two medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8%. (Resident 118) Finding includes: On 8/16/22 at 4:38 p.m., QMA 2 was observed preparing Resident 118's medications, which included diclofenac gel (a topical pain medication). She put a small amount of the gel into a medication cup and entered the resident's room. She donned gloves and applied the gel to the resident's left knee. Resident 118 then asked if QMA 2 was going to put some of the gel on her right shoulder and indicated that was where it was	F 0759	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F759 Med Error Greater than 5%** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #118- 1:1 education completed with QMA #2. Education included topical	09/07/2022

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	supposed to be applied. QMA 2 removed her gloves, went back to the medication cart, put some more of the gel into a medication cup and re-entered the resident's room. She donned gloves and applied the gel to the resident's right shoulder and back. QMA 2 had not measured the amount of gel prior to administering it. Resident 118's record was reviewed on 8/16/22 at 4:50 p.m. A Physician's Order, dated 8/10/22, indicated diclofenac sodium external gel 1%, 4 grams, apply to right shoulder and back topically three times a day. Interview with QMA 2 on 8/16/22 at 4:45 p.m., indicated she should have applied the gel to the resident's right shoulder and back as the order indicated. She was not aware of how to measure the amount of gel ordered and should have asked the nurse for assistance. A facility policy, titled, "Medication Administration, Administration of Treatments/Topical Medications," indicated, "A. Nurse reviews the order ...O. If needed, chooses an appropriate applicator to remove medication/treatment from the container. Once used, applicator is never reintroduced into the container ...P. Applies treatment as per the Physician's order ..." 3.1-48(c)(1)		medication appropriately being measured and applied to correct site. Resident #118 reviewed with no ill effects due to the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents with an order for topical medications related to pain have the potential to be affected by this alleged deficient practice. · Topical medication audit review completed to review all current residents utilizing Topical pain medications reviewed. Audit in place to ensure topical pain medications are measured and administered as ordered on correct site. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on proper application and measurement of Topical medications. · Director of Nursing/Designee will randomly	

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			audit 5 residents each week for proper topical TX measurement and application. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect proper application and measurement weekly. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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, record review and interview, the facility failed to ensure a medication cart was locked at all times while unattended for 1 of 3 medication carts observed. (C Wing) Finding includes: On 8/16/22 at 4:17 p.m., QMA 2 was observed at her medication cart preparing to pass medications. She indicated she needed to go look to see if a new medication had arrived yet. She walked away from her medication cart and left the cart unlocked. The cart was not in sight of QMA 2 or any other staff member. At 4:32 p.m., QMA 2 returned to the medication cart. Interview with QMA 2 on 8/16/22 at 4:32 p.m., indicated she had left the medication cart unlocked.	F 0761	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F761 Med Storage Med cart was left unlocked and unattended** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · QMA #2 immediately	09/07/2022

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	Interview with the DON on 8/17/22 at 8:53 a.m., indicated she would provide the current policy on medication storage. A facility policy, titled "Medication Storage in the Facility," indicated, "...B...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access..." 3.1-25(m)		provided education to ensure medication cart is locked prior to departure. · All med carts checked immediately to ensure when unoccupied that med carts are locked and secured. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents have the potential to be affected by this alleged deficient practice. All med carts were checked to ensure if unattended carts, are locked and secured. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Clinical staff were educated that all med carts are to be locked upon departure of their med cart. · Director of nursing/Designee will randomly audit all med carts 5x a week to ensure med carts are locked and secured when unattended. **How will the corrective**	

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			actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Director of Nursing/designee will continue to complete audit tool to ensure all med carts are properly locked and secured when unattended. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0812 SS=E 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			

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	155844	A. BUILDING 00 B. WING	08/18/2022

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	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 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, record review and interview, the facility failed to ensure food equipment was clean and nursing staff changed gloves in between touching food and other items for 1 of 1 kitchens and 1 of 1 random observations during dining. (The Main Kitchen and Resident 177) Findings include: 1. During the brief kitchen sanitation tour on 8/11/22 at 9:30 a.m., with the Dietary Food Manager (DFM) the following was observed: a. There was a large amount of dirt and dust on both oven hoods. b. There was a large amount of dried and burned food on the grill grates. c. There was a heavy accumulation of grease on the side and top of the deep fryer. There was a large amount of food crumbs and particles noted. d. The stove top grates were dirty with dried and burned food. e. The griddle was dirty with a moderate amount of food residue.	F 0812	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F812 Kitchen Sanitation-** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All oven hoods, grates, griddles, and deep fryers were cleaned immediately. 1:1 education provided with Executive Chef regarding kitchen sanitation. · Resident #177- RN #1 educated on proper food handling and utilization of gloves immediately. Resident #177 consumed food with no ill effects due to alleged deficient practice.	09/07/2022

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	Interview with the DFM on 8/17/22 at 10:15 a.m., indicated all of the above was in need of cleaning. 2. On 8/15/22 at 1:25 p.m. RN 1 donned a pair of clean gloves to both hands and began to assist Resident 177 with her meal. She touched the resident's arm with one of her gloved hands and then picked up the packages of ketchup and mustard off of the plate. She opened both packets and put them on her hamburger. The RN took a knife and with her gloved hands touched the burger and cut it into quarter slices. She then picked up french fries with her gloved hands and placed them back on the plate. She did not change her gloves out after touching the food and all of the other non-food items. She removed her gloves, performed hand hygiene and walked away. Interview with the Director of Nursing on 8/17/22 at 10:30 a.m., indicated the nurse should not have touched the resident's food with the gloved hands after handling other non-food items on the tray. 3.1-21(i)(3)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents have the potential to be affected by these alleged deficient practices. · Cleaning audits of kitchen grates, griddles, and deep fryers weekly to ensure proper sanitation practices are followed. · Audit for proper glove usage and proper glove disposal/new application during meals weekly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on kitchen sanitation. · Facility staff were educated on utilization of clean gloves when food handling. · The Executive Chef/designee will complete audit tool to reflect proper sanitation schedules are in place and clean appliances weekly.	

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			· Director of Nursing/Designee to audit 3 meals a week to ensure proper food handling. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Executive Chef/designee will complete audit tool to reflect proper sanitation schedules are in place and clean appliances weekly. · DON/Designee will audit random food handling 3x weekly to ensure proper food handling. · The Executive Chef/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on random observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to N95 masks not removed after leaving transmission based precaution (TBP) isolation rooms, not containing dirty dishes after leaving a COVID-19 positive room, and not wearing appropriate personal protective equipment into a TBP isolation room during random infection control observations. (Residents 30 and 161)	F 0880	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F880 Infection Control -** **What corrective action(s) will be accomplished for those**	09/07/2022

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	Findings include: 1. During a random observation on 8/12/22 at 8:20 a.m., CNA 1 was observed leaving Resident 30's room. The CNA was wearing a face shield and an N95 face mask. The signage on the outside of the resident's room door indicated a Red Stop Sign which meant the resident had tested positive for COVID-19. The CNA did not remove her N95 face mask after leaving the room and then walked into other Green Zone (Covid free) rooms down the hall. 2. During a random observation on 8/12/22 at 8:30 a.m., the HR (Human Resource) assistant was observed leaving Resident 30's room. She was wearing a face shield and an N95 face mask. The HR assistant did not change her mask after leaving the room. She was observed to walk down the hall and enter other Green Zone rooms. . Interview with the HR Assistant on 8/12/22 at 8:34 a.m., indicated she was unaware she had to change her N95 face mask after she left a COVID-19 positive room and before she entered a Green Zone room. 3. During a random observation on 8/15/22 at 1:25 p.m., the dietary aide brought Resident 30's meal tray to the nurses' station. CNA 2 picked up the tray and walked to the resident's room, donned personal protective equipment (PPE) and entered the room to assist the resident with her lunch meal. The food was on a regular plate, tray and glassware. The dishes were not disposable. At 1:47 p.m., CNA 2 left the resident's room and carried the lunch tray down the hallway and placed it in a plastic zipper enclosed transportation cart. The dirty dishware that came		**residents found to have been affected by the deficient practice?** · All dishes contained coming out of COVID (+) rooms in plastic bag and taken to the kitchen individually. · All staff coming in and out of yellow room observed for proper Donning and Doffing. · All staff exiting COVID (+) rooms observed changing N95 masks immediately. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents that are COVID (+) or that are in isolation have the potential to be affected by these alleged deficient practices. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on COVID isolation procedures. · Director of	

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	out of the COVID-19 positive room was not contained as the CNA transported it down the hallway to the nurses' station where the carts were located. Interview with QMA 1 on 8/16/22 at 11:30 a.m., indicated disposable plates and cups were to be used for the residents that were positive for COVID-19. She was going to throw away the real plates inside the room from breakfast that morning. Interview with the Administrator on 8/17/22 at 9:00 a.m., indicated she had in-serviced staff to contain the dirty dishware in a plastic bag to carry down the hall and then place it on the contained transportation carts. The current and updated 2/8/22, "COVID-19 Infection Control Guidance in Long-term Care Facilities" indicated "If facilities have private rooms, there is an option to place COVID-19 residents throughout the facility provided ALL the following could be followed with full diligence without having a red zone. If the facility is not confident of its ability to follow this guidance, they should continue to maintain a red zone for COVID-19 positive residents: - Residents with confirmed COVID-19 should be placed in private rooms with doors closed. - If 2 residents in semi-private rooms are positive for COVID-19 they may remain in their room in TBP. - All individuals must fully don all appropriate PPE (gloves, gown, N95 respirator mask and eye protection) before entering the room, doff and perform hand hygiene before exiting the room. - N95 respirators masks should be discarded upon exit." 4. During a random observation on 8/11/22 at 2:20		Nursing/Designee will audit staff members' Donning/Doffing procedures daily. · Director of Nursing/Designee will observe 2 meals 5x weekly that are COVID (+) for proper meal tray removal. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Director of Nursing/designee will complete audit tool to reflect proper Donning/Doffing procedures and removal of COVID (+) meal trays. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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	p.m., CNA 3 was observed entering Resident 161's room wearing an N95 mask and face shield. The signage on the outside of the resident's door indicated she was in contact/droplet isolation which required personal protective equipment (PPE) including a face shield, N95 mask, gown, and gloves prior to entry of the room. Interview with the Administrator on 8/17/22 at 4:00 p.m., indicated the CNA should have had the appropriate PPE on before entering the isolation room. 3.1-18(b)			
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 record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to remaining on an antibiotic after a negative urine culture for 1 of 6 residents reviewed for unnecessary medications. (Resident 112) Finding includes: The record for Resident 112 was reviewed on 8/15/22 at 11:18 a.m. Diagnoses included, but	F 0881	**Symphony of Chesterton** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F881 Antibiotic Stewardship** **What corrective action(s) will be accomplished for those**	09/07/2022

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	were not limited to, type 2 diabetes mellitus and spinal stenosis of the lumbar region. The Admission Minimum Data Set (MDS) assessment, dated 8/13/22, was in progress. The resident was identified as being moderately impaired for daily decision making. A Physician's Order, dated 8/6/22, indicated the resident was to have a urinalysis (UA) with a culture and sensitivity (C & S) collected. Nurses' Notes, dated 8/9/22 at 3:55 p.m., indicated the UA results were invalid and staff would recollect. A Physician's Order, dated 8/11/22, indicated the resident was to receive Macrobid (an antibiotic) 100 milligrams (mg) twice a day for a urinary tract infection (UTI) for 5 days. The Urine Culture Results, dated 8/12/22, indicated the culture showed no growth. A Laboratory Note, completed by the Physician on 8/12/22 at 7:15 p.m., indicated the urine culture was negative. There was no order to discontinue the antibiotic. Interview with the Director of Nursing on 8/17/22 at 2:18 p.m., indicated the Macrobid should have been discontinued due to the urine culture being negative. 3.1-18(b)(1)		**residents found to have been affected by the deficient practice?** · Resident 112 completed antibiotic with no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents with antibiotics ordered have the potential to be affected by this alleged deficient practice. Antibiotic orders were reviewed to ensure proper stewardship and protocols in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing staff/clinicians were educated on the antibiotic stewardship program and protocols. · Director of Nursing/designee will audit 50% of new antibiotic orders each week to ensure appropriate antibiotic stewardship and protocols are in use.	

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			How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Director of Nursing/designee will complete audit tool to reflect proper antibiotic stewardship. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00380144 and IN00381235. Complaint IN00380144 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00381235 - Unsubstantiated due to lack of evidence.	R 0000	**Symphony of Chesterton Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	

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	Survey dates: August 11, 12, 15, 16, 17, and 18, 2022. Facility number: 013688 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/23/22.		Symphony of Chesterton Kindly requests a desk review	
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 ensure food equipment was clean for 1 of 1 kitchens. (The Main Kitchen) Finding includes: 1. During the brief kitchen sanitation tour on 8/11/22 at 9:30 a.m., with the Dietary Food Manager (DFM) the following was observed: a. There was a large amount of dirt and dust on both oven hoods. b. There was a large amount of dried and burned food on the grill grates. c. There was a heavy accumulation of grease on the side and top of the deep fryer. There was a large amount of food crumbs and particles noted.	R 0273	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **R0273** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All oven hoods, grates, griddles, and deep fryers were cleaned immediately. 1:1	09/07/2022

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	d. The stove top grates were dirty with dried and burned food. e. The griddle was dirty with a moderate amount of food residue. Interview with the DFM on 8/17/22 at 10:15 a.m., indicated all of the above was in need of cleaning.		education provided with Executive Chef regarding kitchen sanitation. · Resident #177- RN #1 educated on proper food handling and utilization of gloves immediately. Resident #177 consumed food with no ill effects due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current facility residents have the potential to be affected by these alleged deficient practices. · Cleaning audits of kitchen grates, griddles, and deep fryers weekly to ensure proper sanitation practices are followed. · Audit for proper glove usage and proper glove disposal/new application during meals weekly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on kitchen sanitation.	

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			· Facility staff were educated on utilization of clean gloves when food handling. · The Executive Chef/designee will complete audit tool to reflect proper sanitation schedules are in place and clean appliances weekly. · Director of Nursing/Designee to audit 3 meals a week to ensure proper food handling. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Executive Chef/designee will complete audit tool to reflect proper sanitation schedules are in place and clean appliances weekly. · DON/Designee will audit random food handling 3x weekly to ensure proper food handling. · The Executive Chef/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	08/18/2022

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			will continue.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to lack of consistent monitoring of residents for 1 of 3 residents reviewed for infection control. (Resident 2) Finding includes: The closed record for Resident 2 was reviewed on 8/17/22 at 1:26 p.m. Diagnoses were not available in the record. The resident was admitted to the facility on 5/13/22 and discharged on 6/11/22. There were two sets of vital signs listed in the record: 5/23/22 at 9:05 a.m. and 6/7/22 at 9:56 a.m. Interview with the Director of Nursing on 8/18/22 at 2:27 p.m., indicated the resident should have at	R 0407	**Symphony of ChestertonPlease accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **R407 Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 2 Discharged from facility on 06/11/2022. · Resident 2 with no ill effect	09/07/2022

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	least two sets of vital signs per day, which included a temperature and an oxygen saturation level. Interview with the Assisted Living Director on 8/18/22 at 2:42 p.m., indicated the staff should have been checking vital signs, including temperature and oxygen saturation, at least twice daily, once in the morning and once in the evening. She was unable to locate the original paper charting that the CNAs filled out once completed. A policy titled, "COVID-19 Clinical Guidance-Indiana Residential," was received from the Assisted Living Director on 8/18/22 at 4:00 p.m. The policy indicated, "General...Guiding Principles...Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry."		rom alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All current residential residents have the potential to be affected by this alleged deficient practice. Covid 19 Screening monitoring tool applied to all current residential residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility staff were educated on the assessment and order entry for proper monitoring and documentation of Covid 19 Screening. · Director of Nursing/designee will audit all new residential admits each week for order entry for proper monitoring and documentation of Covid 19 Screening. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			· The Director of Nursing/designee will complete audit tool to reflect proper application of Covid 19 Screening order. · The Director of Nursing/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	