STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00393843. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00390759 completed on 9/30/22. Complaint IN00393843 - Substantiated. Federal/state deficiencies related to the allegations are cited at F609 and F943. Unrelated deficiency is cited. Complaint IN00390759 - Not corrected Survey dates: November 14 & 15, 2022 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 10 Medicaid: 48 Other: 4 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/18/22.	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator, for 1 of 4 residents reviewed for allegations of abuse. (Resident K)	F 0609	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these	12/05/2022

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	Finding includes: During an interview on 11/14/22 at 10:05 a.m., Resident K indicated there had been a CNA who was very mean when she talked and was rough during care. She indicated she had informed a staff member who had a relative at the facility. She indicated she has had no problems since this incident and felt safe at the facility. The Administrator was informed of the conversation on 11/14/22 at 10:34 a.m. and indicated she was unaware of this allegation. During an interview on 11/14/22 at 10:47 a.m., CNA 3 indicated the resident had concerns a few times "about a month ago" about a CNA being rough with her and her roommate. CNA 3 indicated she had reported it to the nurse on duty and could not recall the name of the nurse she reported this to, but thought it was Nurse 1. She indicated the allegation was made against an Agency CNA, and the CNA had not worked in the facility since. She indicated she had been educated on the facility abuse policy and the Administrator was to be contacted immediately for any allegations of abuse and she had not notified the Administrator. During an interview on 11/14/22 at 11:35 a.m., Nurse 1 indicated no allegation of abuse was reported to her. If the allegation had been reported to her, she would have asked the CNA the allegation was against to leave the facility and have notified the Administrator immediately. A facility abuse policy, dated 6/21/17 and received from the Administrator as current, indicated all allegations of abuse were to be reported immediately to the Administrator or designated		responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12-1-22 to Investigation of Complaints survey IN00393843 and PSR for Investigation of Complaint survey IN00390759 completed on November 14 to November15, 2022. We respectfully request a paper review and will provide any additional information requested. F609 It is the policy of this facility to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility. The corrective action taken for those residents found to be affected by the deficient practice include: Resident K allegation was investigated and reported to the appropriate parties. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action has been taken: Potentially all residents that had abuse allegations could be affected. All residents that are able were interviewed to determine	

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	representative. This Federal tag relates to Complaint IN00393843. 3.1-28(c)		if any allegations of abuse had not been reported to the Administrator. There were no new findings. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: The abuse policy was reviewed by the IDT team. All nursing staff have been in-serviced on the facility abuse policy, including reporting any allegations of abuse immediately to the Administrator. A random audit of staff will be completed to ensure awareness of abuse reporting being communicated immediately to the Administrator. How the corrective action will be monitored to ensure the deficient practice will not recur: A Performance Improvement Tool has been initiated that randomly queries 5 staff regarding when to report allegations of abuse and who to report to. The Director of Nursing or designee will complete these tools weekly X3, monthly X3, then quarterly X3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be complete: 12/5/22	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents received adequate supervision, related to residents who were assessed for supervised smoking observed outside smoking without supervision from the staff, for 2 of 4 residents observed for smoking. (Residents G and L) Finding includes: During an observation on 11/14/22 at 9:39 a.m., there were two residents sitting outside the alarmed door at the end of the 400 Unit, smoking. There was no staff observed outside with the residents or close to the outside exit door. During an interview on 11/14/22 at 11:07 a.m., The Administrator identified the two residents as Resident G and Resident 2. The Director of Nursing indicated they were to be supervised by the staff when smoking. She indicated a staff member had to have given the smoking material to them and opened the door for them and the door they were sitting outside of was an alarmed exit. Resident G's record was reviewed on 11/15/22 at 11:23 a.m. The diagnoses included, but were not	F 0689	It is the policy of this facility to ensure the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. The corrective action taken for those residents found to be affected by the deficient practice include: Resident G and resident L have not smoked unsupervised since occurrence. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken: Potentially all residents who smoke could be affected. All residents who smoke will smoke at designated times per policy only with supervision. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include:	12/05/2022

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	limited to, bilateral below the knee amputation. An Annual Minimum Data Set (MDS) assessment indicated an intact cognitive status, no behaviors, and no impairments of the upper extremities. A Care Plan, dated 3/23/21, indicated he was a cigarette smoker. The interventions included a Smoking Assessment would be completed and the plan of care would be based on the findings of the assessment to ensure safety and safety precautions were addressed. A Smoking Assessment, dated 9/14/22, indicated smoking must be supervised by staff, a volunteer, or a family member at all times. Resident L's record was reviewed on 11/15/22 at 12:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus, stroke, and syncope. A Quarterly MDS assessment, dated 11/18/22, indicated an intact cognitive status and no impairment of the upper and lower extremities. A Care Plan, dated 11/16/21, indicated he smoked cigarettes. The interventions included the resident would be educated on the facility's smoking policy. A Smoking Assessment, dated 11/8/22, indicated his vision was not adequate with or without aid and he must be supervised by staff, a volunteer, or family member at all times when smoking. The facility smoking policy, dated 7/2019 and received from the Director of Nursing as current, indicated the residents were only able to have their smoking materials when under direct supervision. All residents who smoked would be		The smoking policy has been reviewed by the IDT team. All nursing staff have been in-serviced on the facility smoking policy, including supervision requirement for residents who smoke. The smoking policy has been reviewed with residents who smoke, including the supervision requirement. A random audit will be completed to ensure residents who smoke are supervised. How the corrective action will be monitored to ensure the deficient practice will not recur: A Performance Improvement Tool has been initiated that randomly observes 5 residents who smoke for appropriate supervision when smoking. The Director of Nursing or designee will complete these tools weekly X3, monthly X3, then quarterly X3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be complete: 12/5/22	

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	supervised to ensure safety. 3.1-45(2)			
F 0943 SS=F Bldg. 00	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. Based on record review and interview, the facility failed to ensure staff at the facility were trained on the facility's abuse policy and procedure, related to 3 of 4 Agency CNA's not educated on the facility's abuse policy and procedures prior to working with residents. This had the potential to affect all 62 residents who resided in the facility. Finding includes: During an interview on 11/15/22 at 9:29 a.m., CNA 2 indicated she worked for an Agency and this was the first day scheduled at the facility. She indicated she had not been educated on the facility's abuse policy and procedures. During an interviews on 11/15/22 at 10:42 a.m., the	F 0943	It is the policy of this facility to ensure that all staff, including agency staff are provided training to educate them on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. The corrective action taken for those residents found to be affected by the deficient practice include: Agency C.N.A's # 2, 4 and 5 have been educated on the facility	12/05/2022

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	Administrator indicated it was the responsibility of Human Resources (HR) to ensure all Agency Staff are educated on the abuse policy and procedures. HR staff indicated the education on the abuse policy and procedures had not been completed yet for the Agency Staff in the building. She was not at the facility when the CNA's came in to start work. During an interview on 11/15/22 at 10:50 a.m., CNA 4 indicated she was Agency Staff and had started work at 6:30 a.m.. She had not been educated on the facility's abuse policy and procedures. During an interview on 11/15/22 at 10:55 a.m., CNA 5 indicated she was Agency Staff and she had also worked on 11/14/22. She indicated she had not been educated on the facility's abuse policy and procedures. A facility abuse policy, dated 6/2017 and received as current from the Administrator, indicated upon initial employment, the employee would be provided a copy of the facility's abuse policy and procedures, which included identification and reporting requirements. This Federal tag relates to Complaint IN00393843.		policy on abuse and the procedure for reporting. How have other residents with the potential of being affected by the same deficient practice been identified and what corrective action was taken: Potentially all residents could be affected. Education on abuse is being completed for all staff prior to working with residents. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nursing staff, including agency staff have been in-serviced on the facility abuse and reporting policy. All nursing staff, including agency staff, will receive training to educate them on the facility abuse and reporting policy prior to working with residents. A random audit will be completed to ensure nursing staff has completed the abuse policy and reporting training prior to working with residents. How the corrective action will be monitored to ensure the deficient practice will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 nursing staff, including agency staff, for completion of abuse policy and reporting training prior to working with residents. The Director of Nursing or designee will complete these tools weekly X3, monthly X3, then quarterly X3. Any issues identified	

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			will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic change will be complete: 12/5/22	