STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155694	A. BUILDING 00 B. WING	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETZ NURSING HOME	116 BETZ RD AUBURN, IN 46706

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 24, 25, 26, and 27, 2022 Facility number: 000306 Provider number: 155694 AIM number: 100273860 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 52 Other: 19 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review compelted July 28, 2022	F 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance. Facility respectfully requests desk review in lieu of on-site revisit.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed in the required time frame for 2 of 2 residents reviewed. (Resident 17 and Resident 25)	F 0638	**F 638 Quarterly Assessment at Least Every 3 Months** It is the practice of this provider to submit Quarterly Review Assessments at least every 3 months for each resident.	08/12/2022

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

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	Findings include: 1. Resident 17's record review began on 7/26/22 at 3:00 PM. The record indicated an annual MDS was accepted with warning on 3/30/22. The assessment reference date was 3/29/22. In addition, the record indicated a quarterly review had been in process since 6/22/22, but had not been transmitted by the time of survey exit. 2. Resident 25's record was reviewed on 7/26/22 at 9:30 am. The record indicated an annual MDS was accepted with warning on 3/30/22. The assessment reference date was 3/25/22. In addition, the record indicated a quarterly review had been in process since 6/16/22, but had not been transmitted by the time of survey exit. The Director of Nursing was interviewed on 7/26/22 at 9:34am. She indicated MDS quarterly assessments were to be done within 92 days of the previous assessment. The MDS coordinator was interviewed on 7/26/22 at 11:50am. She indicated MDS quarterly assessments were to be completed within ninety-two (92) days from the last assessment. She indicated the quarterly review dated 6/16/22 should have been completed by 6/30/22 and transmitted within 31 days after the assessment was completed. A policy, dated 10/2019, entitled, "RAI OBRA-required Assessment Summary" was received from the DON on 7/26/22 at 9:59am. The policy indicated the assessment reference date was required to be within 92 days of the last assessment. The policy also indicated the completion date should have been within 14 days of the assessment reference date.		**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Minimum Data Set (MDS) assessments were completed and submitted for 2 of 2 residents identified (resident #17 and resident #25). **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Audit completed for all residents and all assessments are up to date. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** MDS Coordinator to report in daily morning meeting what quarterly assessments are due and IDT to follow assessment through completion and submission to ensure submitted on or before due date. Policy reviewed with MDS Coordinator and IDT. Morning Meeting form modified to include IDT discussion and tracking of MDS assessments due to ensure they are submitted on time. IDT re-educated on process of quarterly assessments, due dates, and expectations of each section being completed so assessment is submitted on or	

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	3.1-31(d)(3)		before due date. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/DNS/Designee to complete QAPI tool for MDS quarterly assessments weekly x 4, monthly x 3, and quarterly x 3. If 95% is not achieved an action plan will be developed. Results will be reviewed during monthly QAPI meeting.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in			

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	disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review the facility failed to ensure quarterly care plan meetings were completed for 2 of 2 residents reviewed. (Resident 10, Resident 46) Findings Include: 1. Resident 10 was interviewed on 7/24/22 at 12:47 PM. Resident 10 indicated she did not have care plan meetings. Resident 10's record was reviewed on 7/25/22 at 3:25 PM. An Minimum Data Set (MDS) assessment, dated 3/24/22 indicated Resident 10 had a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact. Social Service (SS) notes were reviewed for Resident 10 from 2/1/22 - 7/25/22. The notes indicated there were care plan meetings on 2/24/22 and 7/14/22. There was no other documentation regarding care plan meetings. 2. Resident 46 was interviewed on 7/24/22 at 12:18 PM. Resident 46 indicated she did not have care plan meetings. Resident 46's record was reviewed on 7/25/22 at 2:03 PM. An MDS assessment, dated 5/17/22 indicated Resident 46 had a BIMS score of 15 indicating cognitively intact. SS notes were reviewed for Resident 46 from	F 0657	**F 657 Care Plan Timing and Revision** It is the practice of this provider to ensure quarterly care plan meetings are completed for all residents in accordance with state and Federal regulations. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** The two residents in question were self-identified by the provider and care plan meetings were both held in July prior to survey. One held 7/14/22 and the other held 7/7/22. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Full facility audit completed. Care Plan invites sent and meetings scheduled for those due. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** IDT team reviewed policy “IDT Comprehensive Care Plan Policy”. Daily Morning Meeting form updated to include daily	08/12/2022

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	2/1/22 - 7/25/22. The notes indicated there were care plan meetings on 2/24/22 and 7/7/22. There was no other documentation regarding care plan meetings. The Social Service Director (SSD) was interviewed on 7/25/22 at 3 PM. The SSD indicated care plan meetings were completed quarterly. The SSD indicated Resident 10 and Resident 46 should have had a care plan meeting in May 2022. A policy, revised 10/2019, titled "IDT Comprehensive Care Plan Policy," was provided by the Director of Nursing on 7/26/22 at 12:40 PM. The policy did not indicate how often care plan meetings should be completed. A review of CMS.GOV website under MDS Care plan timing Chapter 5, Care plan meetings must be held within 7 days of MDS completion. 3.1-35(d)(2)(B)		discussion of what care plan meetings are due for the week and they will correlate with the MDS assessments each quarter. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/DNS/SSD/Designee to complete QAPI tool Quarterly Care Plans weekly x 4, monthly x 3, and quarterly x 3. If 95% is not achieved an action plan will be developed. Results will be reviewed during monthly QAPI meeting.	
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, interview and record review, the facility failed to ensure nail care was completed for 1 of 1 resident reviewed. (Resident 44) Findings include: Resident 44's record was reviewed on 7/24/22 at 1:50 PM. Diagnoses included Alzheimer's disease.	F 0677	**F 677 ADL Care Provided for Dependent Residents** It is the practice of this provider to ensure residents receive nail care as part of nursing standard of care to ensure the highest well-being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those**	08/12/2022

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	A review of Residnet 44's MDS (Minimum Data Set) assessment dated 5/4/22 indicated the resident did not have a Brief Interview of Mental Status (BIMS) conducted since the resident was rarely or never understood. The record indicated Resident 44 required extensive assistance with activities of daily living. An interview was conducted with the family of Resident 44 on 7/24/22 at 12:44 PM. A family member indicated there was a dark brown substance visible under Resident 44's fingernails. The family member indicated she witnessed Resident 44 placing her hands in feces during care on several occasions in the past. An observation was made on 7/24/22 at 12:44 PM. Resident 44's fingernails were of various lengths with some jagged edges and a dark brown substance was under the nails on both hands. An observation was made on 7/25/22 at 10:44 AM. Resident 44's fingernails were of various lengths with some jagged edges and a dark brown substance was under the nails on both her hands. In an interview on 7/26/22 at 11:09 AM, Licensed Practical Nurse (LPN) 3 indicated Certified Nursing Assistant's (CNA) normally provide nail care. In an interview on 7/26/22 at 11:13 AM, CNA 4 indicated resident nails are to be checked during care and cleaned when indicated. Resident 44's shower report dated 7/24/22 indicated nail care had been given on that day. In an interview on 7/25/22 at 2:55 PM, the DON indicated that there was no formal policy for nail		**residents found to have affected by the deficient practice?** Resident # 44 had nailcare provided which included cleaning and trimming on 7/25/22. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All resident's nails observed by nurse managers to ensure no other residents affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Clinical staff re-educated on the services provided with AM care, shower care, and overall standard of care and that nailcare is to be provided at any time resident nails are observed dirty or needing trimmed. C.N.A. Care Sheets updated to include "Nail Care Daily" as a visual reminder to floor staff. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ADNS/DNS/ED/Designee to complete QAPI tool for ADL Nail Care daily x 14, weekly x 4 weeks, monthly x 6 months. If 95% is not achieved an action plan will be developed. Results	

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	care, and nail care was considered a standard of CNA care. During an observation on 7/26/22 at 9:27 am, Resident 44's nails were of consistent length with no jagged edges and no dark brown substance was visible under the nails. 3.1-38(a)(3)(E)		will be reviewed during monthly QAPI meeting.	