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	06/27/2023

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

(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. Survey dates: June 20, 21, 22, 26 and 27, 2023 Facility number: 000306 Provider number: 155694 AIM number: 100273860 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 57 Other: 14 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 30, 2023	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 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Northington	Executive Director	07/19/2023

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

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	06/27/2023

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

(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
	procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review the facility failed to ensure the provision of timely laboratory testing to monitor warfarin (blood thinner) for 1 of 4 residents reviewed. (Resident 183) Findings include: Resident 183's record was reviewed on 6/26/23 at 2:19 PM. Diagnoses included a history of a blood clots. Resident 183's current Comprehensive Minimum Data Set (MDS) assessment dated 6/6/23 indicated their Brief Interview for Mental Status (BIMS) was 15 (no cognitive deficit). The MDS indicated the resident was being administered a blood thinner for a history of blood clots. A physician order dated 6/16/23 indicated a PT/INR (blood test for blood thinning medication) was to be performed on 6/23/23. Progress notes dated 6/23/23 through 6/26/23 had no indication of a PT/INR blood draw attempt. In an interview on 6/26/23 at 3:24 PM the Director of Nursing (DON) indicated the PT/INR scheduled for 6/23/23 was not performed due to Resident 183 having had difficult veins. The DON indicated the PT/INR was collected on 6/26/23 and results were anticipated between 5:00 PM and 6:00 PM. The DON indicated the ADON notified the Nurse Practitioner (NP) on 6/23/23 of the missed blood test and received an order to perform the blood test on 6/26/23.	F 0773	F 773 It is the practice of this provider to ensure timely laboratory testing. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The lab draw was completed for resident #183 on 6/26/23 and results obtained on the same date. **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 labs and no other residents were 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?** All nurses in-serviced on Labs and Diagnostics Policy as well as Guidelines for Lab and Radiology Tracking on 6/27/23 **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?** DNS/Designee to complete QAPI tool for Labs/Diagnostics daily x 7, weekly x 4, monthly x 5. If 95% is not achieved an action plan will be developed. Results will be	07/19/2023

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	06/27/2023

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

(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
	In a telephone interview on 6/26/23 at 3:32 PM a Laboratory Representative (Lab Rep) 5 indicated there was no physician order for Resident 183's PT/INR to be performed on 6/26/23. Lab Rep 5 indicated the only physician order for Resident 183's PT/INR was dated 6/22/23 at 7:59 PM. The blood draw should have been performed on 6/23/23. In an interview on 6/26/23 at 3:36 PM the DON indicated the facility had followed the physician order to perform the PT/INR on 6/26/23. The DON indicated the NP was made aware of the failed PT/INR attempt by the ADON on 6/23/23. The DON indicated on 6/23/23 the NP gave an order to the ADON for the PT/INR to be drawn 6/26/23. The DON indicated the PT/INR was collected the morning of 6/26/23 and results were pending. The DON indicated lab results were generally received from the lab between 5:00 PM and 6:00 PM due to the lab's location being in Indianapolis. In an interview on 6/26/23 at 4:02 PM Resident 183 indicated the nurse had drawn their blood. Resident 183 indicated there were no other attempts at drawing their blood on 6/26/23. The resident indicated a lab technician had failed at obtaining a blood sample on Friday morning 6/23/23. The resident indicated there had been no attempts to draw her blood between 6/23/23 and 6/26/23. In an interview on 6/26/23 at 4:15 PM Registered Nurse (RN) 4 indicated they had drawn Resident 183's blood at approximately 3:30 PM. On 6/27/23 at 8:45 AM Resident 183's record was reviewed. A progress noted entered by RN 4 dated 6/26/23 at 3:37 PM indicated Resident 183's		reviewed during monthly QAPI meeting. **5. What date the systemic changes for each deficiency will be completed: 07/19/2023**	

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	06/27/2023

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

(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
	blood was drawn due to the lab being unable to obtain a redraw. The entry was invalidated on 6/26/23 at 3:47 PM. A PT/INR lab report indicated Resident 183's blood was drawn on 6/26/23 at 3:30 PM. A review of a PT/INR Tracking Log indicated Resident 183's PT/INR test was performed on 6/16/23 and the next PT/INR test should be completed on 6/23/23. There was no documentation of the missed lab draw, physician notification or an order to draw the lab on an alternate date. A progress note entered by the ADON dated 6/23/23 at 3:25 PM recorded as a late entry on 6/26/23 at 3:27 PM indicated the NP was informed Resident 183's PT/INR had not been drawn and could be drawn on 6/26/23. A progress note entered by the NP dated 6/23/23 at 3:29 PM recorded as a late entry on 6/26/23 at 3:34 PM indicated PT/INR results were pending due to an inability to collect the sample on 6/23/23. In an interview on 6/27/23 at 10:15 AM the DON indicated the blood was drawn by RN 4 on 6/26/23 at 3:30 PM due to the lab had been unable to collect blood on the morning of 6/23/23. The DON indicated they had no knowledge as to why the progress note related to the blood draw dated 6/26/23 at 3:37 was invalidated on 6/26/23 at 3:47 PM. The DON indicated they were unaware as to why there was no documentation in the progress notes related to an unsuccessful lab draw. The DON indicated they were unaware as to why there was no documentation related to the unsuccessful lab draw and updated physician order on the			

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	06/27/2023

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

(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
	resident's PT/INR Tracking Log. The DON indicated they were unaware as to why the physician order to obtain a PT/INR on 6/26/23 was not included on the physician order sheet. The DON indicated they were unaware as to why the lab did not have a physician order to draw a PT/INR on 6/26/23. A current policy dated 1/2016 provided by the DON on 6/26/23 at 3:36 PM indicated residents requiring warfarin would receive adequate monitoring. The policy indicated all PT/INR results, current warfarin dose, dosage change, physician notification, and relevant comments would be documented on the PT/INR Tracking Log. 3.1-49(a) and (b)			
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 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.			

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	06/27/2023

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

(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
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained for 76 of 76 residents who ate meals prepared in the kitchen. During an observation with the dietician on 6/20/23 at 9:23 AM, A tray of eggs was observed on a shelf inside the walk-in cooler. The tray contained 15 intact eggs on one side and the other side contained eggshells with a clear slimy substance visible on the shells and on the tray around the shells. The dietician indicated cracked shells from egg use should not be stored with clean, intact eggs. In the walk-in freezer, two plastic grocery bags were observed on a shelf filled with containers of ice cream. The Dietician indicated the containers had been opened and were not labeled. The Dietician indicated items should be dated upon opening. In an interview on 6/20/23 at 9:28 AM, Cook 3 indicated she had used the tray of eggs observed in the walk-in cooler during breakfast that morning. She indicated she cracked each egg, discarded its shell on the same tray containing the clean supply and placed the tray in the walk-in cooler after breakfast service was over. She also indicated the ice cream containers in the walk-in freezer belonged to the activities department and the employee who opened them should have dated them upon opening. During an observation of a storage rack	F 0812	F 812 Food Procurement Store/Prepare/Service-Sanitary It is the practice of this provider to ensure kitchen sanitation is maintained. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Culinary staff immediately corrected issues identified. **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 and no other residents were 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?** Culinary Manager initiated a Sanitation Action Plan on 6/20/23 upon communication of identified issues, all action plan items completed by 6/27/23. Additional training and re-education provided for culinary staff on egg shells not allowed in fridge, completed 6/26/23 for all culinary staff. Food Storage policy reviewed for proper dating and labeling on 6/26/23 for culinary staff and on 6/27/23 for	07/19/2023

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	06/27/2023

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

(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
	containing stacks of baking dishes, clear liquid dripped from 3 of 4 stacks of bakeware when separated. The Dietician indicated the bakeware should have been air dried prior to stacking and storing. A container of cut up cabbage was observed on the countertop. A serving spoon and tongs were lying on top of the cabbage with the handles touching the food supply. The Dietician indicated the handles should not touch the food supply. During an observation with Cook 2 on 6/20/23 at 10:43 AM, Cook 2 indicated she had never tested chemical levels in sanitizer water. Cook 2 indicated she did not know how to tell if sanitizer levels were correct. Cook 3 handed Cook 2 a test strip and instructed her to immerse it in the sanitizer water. After immersion, Cook 3 indicated the sanitizer levels were low and the water should be changed. During an interview with Cook 2 on 6/20/23 at 10:57 AM, Cook 2 indicated she did not know how to test sanitizer water because she was a new employee. During a record review on 6/20/23 at 11:15 AM, an Employee Records document provided by the Administrator indicated Cook 2 was hired on 10/26/22. A current skills validation form dated 11/17 provided by the Administrator on 6/21/23 at 10:25 AM identified staff testing of sanitizer solution for appropriate sanitizer concentration as a skill required for cleaning and sanitizing kitchen surfaces. A current policy titled Food Storage dated 5/23		activity staff. Manual Dishwashing Policy reviewed with culinary staff on 6/26/23, staff re-educated on proper procedure to dry/store pans and dishes to avoid wet nesting. Kitchen Safety Guidelines Policy reviewed with culinary staff on 6/26/23 and staff re-educated on the proper positioning of serving utensils and what to do if handles touch the food. All culinary staff re-educated on how to test sanitizer water. Sanitation Bucket Skills Validation reviewed with staff and return demonstrations for sanitizer water level monitoring completed on 6/20/23, with all culinary staff passing skills validation. **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/Culinary Manager/Designee to complete QAPI tool Food Procurement, Store/Prepare/Serve - Sanitary 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. **5. What date the systemic changes for each deficiency will be completed: 07/19/2023**	

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	06/27/2023

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

(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
	provided by the Dietician on 6/20/23 at 11:25 AM indicated food should be clearly labeled and marked to indicate the date by which the food should be used or discarded. A current policy titled Manual Dishwashing dated 6/23 provided by the Administrator on 6/21/23 at 11:19 AM indicated all items should be air dried before use or storage. A current policy titled FDA Food Code dated 2022 provided by the Administrator on 6/21/23 at 11:19 AM indicated food preparation and dispensing utensils should be stored with their handles above the top of the food container. During an interview with the Administrator on 6/21/23 at 11:19 AM, she indicated the facility did not have a policy specific to egg handling and storage. 3.1-21(i)(2)(3)			