STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00451478. Complaint IN00451478 - Federal/state deficiencies related to the allegations are cited at F688 and F641. Survey dates: February 10, 11, and 12, 2025 Facility number: 000514 Provider number: 155503 AIM number: 100266800 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 7 Medicaid: 51 Other: 16 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 20, 2025.	F 0000	ISDH ATT: Suzanne Williams Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Suzanne, On Feb 12,2025 complaint survey (Survey ID WXYT11) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 03/11/2025. Please feel free to call me with any further questions at 1 (812) 446-2636.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Manoj Berry	Executive Director	03/04/2025

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			Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 9 residents' MDS assessments reviewed (Resident E). Findings include: During an observation on 2/10/25 at 2:00 p.m., Resident E was sitting up in her wheelchair with a tray table attached to the right side of her wheelchair. Her right arm was resting on the table. Resident E's record was reviewed on 2/12/25 at 9:42 a.m. An admission MDS assessment, dated 12/9/24, indicated the resident had severe cognitive impairment and no functional limitation in range of motion (ROM) to the upper or lower extremities. Diagnoses on the resident's profile included, but were not limited to, hemiplegia (paralysis or weakness on one side of the body) unspecified affecting right dominant side. An admission observation, dated 12/3/24, indicated the resident had impairment on one side of the upper extremities.	F 0641	F-0641 Accuracy of Assessments Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the residents(s) found to have been affected include: Resident # E was reassessed on cognition impairment and her functional abilities on her extremities. Her care plans and orders including MDS were updated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. No residents were	03/11/2025

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	A Physician's Progress Note, dated 12/4/24, indicated the resident's assessment showed right sided hemiparesis (weakness or paralysis on one side of the body). A care plan, initiated on 12/4/24, indicated the resident was at risk for self-care deficit related to right sided hemiplegia. During an interview, on 2/12/25 at 10:44 a.m., Certified Nurse Aide (CNA) 4 indicated Resident E was not able to use her right arm or hand at all. Resident E used her left hand and arm to put on a shirt and perform other activities. The resident used the tray table to rest her arm on when she was in the wheelchair. During an interview, on 2/12/25 at 10:51 a.m., the MDS Coordinator indicated she was not sure if the resident's hemiplegia should have been coded as an impairment in ROM because the resident was able to walk. She indicated she would check if the impairment to the resident's upper extremity should have been coded. During an interview, on 2/12/25 at 12:02 p.m., the DON indicated Resident E's limitation in ROM should have been coded on the MDS assessment but, it had been missed. On 2/12/25 at 12:14 p.m., the DON provided the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual version 3.0, Section GG, dated October 2024, and indicated it was the policy currently being used by the facility. The RAI Manual indicated, "...GG0115: Functional Limitation in Range of Motion. Code for limitation that interfered with daily functions or placed resident		identified to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Nurse Consultant and the Director of Nursing Services with all licensed staff including MDS Coordinator(s) addressing the importance of identifying the changes to functional abilities and notify DON and MD. 4. How the corrective action(s) will be monitored to ensure the practice will not re-occur: The Director of Nursing Services, designee, will conduct a random audit of five (5) residents per week including new admissions for four (4) consecutive weeks, then 3 residents per week for 4 weeks and 1 resident per week for 4 months. These residents and their medical records will be assessed to ensure that all the dx and ROM, Impairment are identified, properly evaluated and documented in the medical record. Findings of this audit will be discussed with the IDT team and MD. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Compliance date:03/11/2025	

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	at risk for injury in the last 7 days. Coding: 1. No impairment. 1. Impairment on one side. 2. Impairment on both sides...Upper extremity (shoulder, elbow, wrist, hand)...Steps for Assessment: 1. Review the medical record for references to functional range-of-motion limitation during the 7-day observation period. 2. Talk with staff members who work with the resident as well as family/significant others about impairment in functional ROM. 3. Coding for functional ROM limitations is a three-step process: Test the resident's upper and lower extremity ROM...If the resident is noted to have any limitation of upper...ROM, review GG0130 and GG0170 and/or directly observe the resident to determine whether the limitation interferes with function or places the resident at risk for injury. Code GG0115A and GG0115B as appropriate based on the above assessment...." This citation relates to complaint IN00451478.			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on interview, observation, and record review, the facility failed to ensure limitations in range of motion were assessed, treated, and required interventions communicated to staff effectively for 3 of 3 residents reviewed for limitations in range of motion (Residents B, E, and F). Findings include: 1. During an interview, on 2/10/25 at 12:00 p.m., Resident B's family member indicated the resident had splints for her hands that she needed to prevent contractures (permanent or prolonged shortening of muscles, tendons, ligaments, or skin	F 0688	F688 Increase/Prevent decrease in ROM/MOBILITY Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.	03/11/2025

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	that restricts range of motion and can lead to deformities). The splints arrived to the facility with the resident at admission and were kept beside. The splints were not used until 12/14/24. The family member indicated they asked staff about using the splints, but the staff were not aware of them. On 12/13/24, therapy put the splints on the resident and indicated if there was no redness or soreness they would be used at night. On 12/14/24, a regimen for the hand splints was finally established. Resident B's record was reviewed on 2/10/25 at 2:18 p.m. An admission Minimum Data Set (MDS) assessment, dated 12/9/24, indicated the resident had severe cognitive impairment and no functional limitation in range of motion (ROM) to the upper extremities. Census information indicated the resident was admitted to the facility on 12/3/24. An admission Minimum Data Set (MDS) assessment, dated 12/9/24, indicated the resident had severe cognitive impairment and no functional limitation in range of motion (ROM) to the upper extremities. A nursing admission assessment, dated 12/3/24, indicated the resident had weakness and a functional limitation in ROM on both sides of the upper extremities. Other equipment the resident brought included "hand braces." A Physician's Order, dated 12/5/24, indicated skilled Occupational Therapy (OT) services five times a week for four weeks to address basic activities of daily living (ADLs), wheelchair positioning, patient safety, patient education, following directions, therapy exercises and		Immediate action(s) taken for the residents(s) found to have been affected include: Resident B no longer resides in the building. Resident E and F were reassessed by DON and all orders and care plan were updated. MD and POA notified, and a treatment plan were initiated. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility who require splints to prevent decline in ROM, according to person-centered care plans, have the potential to be affected by this practice and no other residents were affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A log of residents requiring use of splints, in accordance with care plan review, was created by the MDS Nurse/DON and will be updated monthly. MDS Nurse/DON will visualize splints monthly and refer residents to the therapy department if any problems are noted. MDS Nurse/DON and Director of Therapy Services provided in-service education programs for direct care staff regarding the use of splints for residents requiring same and to notify DON/MD immediately if changes occur. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: DON/Designee	

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	activities, and upper body strengthening. A care plan, dated 12/11/24, indicated the resident was at risk for impaired mobility related to osteoporosis (weak and brittle bones) an osteoarthritis (chronic joint disease). The care plan lacked documentation of the resident's functional limitation in ROM and the resident's hand splints. An OT Treatment Encounter Note, dated 12/13/24, indicated, "...stretching to bilateral [both] hands prior to application of splints. Hand splints worn for 3 hours without sign of increased skin irritation...." The note lacked documentation the need for hand splints was communicated to the nursing staff. A Treatment Administration Record (TAR), dated December 2024, included two Physician's Orders, dated 12/19/24. The orders indicated hand splints on during the night and off during the day. The TAR lacked documentation the hand splints were ordered prior to 12/19/24. An OT Discharge Summary, dated 12/26/24, included a short term goal of increased ROM and strength in the resident's left upper extremity. Goal notes, dated 12/18/24 and 12/24/24, indicated the resident's left hand continued to struggle with grasp and release due to contractures. During an interview, on 2/11/25 at 11:30 a.m., Certified Occupational Therapy Assistant (COTA) 6 indicated he was familiar with Resident B, and both of her hands were "basically contracted." During therapy, he massaged and stretched her hands. The resident was able to wear the hand splints in therapy for three hours without redness, and eventually wore them at night. The residents		will observe 3 residents for 5 days for 1 week for those residents requiring the use of splints to ensure proper and consistent use of the splints. After one week, DON/Designee will review care for a random sample of 3 residents requiring splints at least three (3) times per week for (4) weeks, then 3 residents 2 times a week for 4 weeks and 3 residents 1 time a week for 4 months to assure the proper and consistent use of recommended splints. Results will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. Compliance date: 03/11/2025	

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	hands were contracted when she was admitted to the facility. He thought the family brought the splints in after she was admitted, but he was not told about them for a couple of days. He was not aware the splints came with the resident upon admission. Once he became aware of the splints, he began to work with the resident to wear them. During an interview, on 2/11/25 at 12:12 p.m., the Director of Nursing (DON) indicated Resident B's hands had impaired mobility, but she was not sure if they were contracted. She did not think the hand splints arrived to the facility until later, after admission. Upon review of the admission assessment, she indicated the hand splints were noted on the resident's admission. If a resident was admitted to the facility with hand splints the staff should have notified the therapy department so therapy could work with the resident on how and when the splints should have been applied. During an interview, on 2/11/25 at 2:06 p.m., the MDS Coordinator indicated a care plan should have been initiated, on 12/19/24, when the hand splints were ordered. If the hand splints arrived with the resident on admission, then the physician should have been consulted at admission to determine the orders for the hand splints. Had the hand splints been ordered at admission, they would have been added to the resident's care plan then. 2. During an observation on 2/10/25 at 2:00 p.m., Resident E was observed sitting up in her wheelchair with a tray table attached to the right side of the chair. The resident's right arm was resting on the tray table. Resident E's record was reviewed on 2/12/25 at 9:42 a.m. An admission Minimum Data Set (MDS)			

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	assessment, dated 12/9/24, indicated the resident had a severe cognitive impairment. Census information indicated the resident was admitted to the facility on 12/3/24. Diagnoses on the resident's profile included, but were not limited to, hemiplegia (paralysis or weakness on one side of the body) unspecified, affecting the right dominant side. An admission observation, dated 12/3/24, indicated the resident had impairment on one side of the upper extremities. A Physician's Progress Note, dated 12/4/24, indicated the resident's assessment showed right sided hemiparesis (weakness or paralysis on one side of the body). A care plan, initiated on 12/4/24, indicated the resident was at risk for self-care deficit related to right sided hemiplegia. The care plan lacked documentation of the the right-sided tray table. Current Physician's Orders lacked documentation of an order for the right-sided tray table. An Occupational Therapy (OT) Discharge Summary, dated 1/30/25, lacked documentation the resident was assessed or treated by OT for the use of the right-sided tray table. During an interview, on 2/12/25 at 10:44 a.m., Certified Nurse Aide (CNA) 4 indicated the resident was not able to use her right arm or hand. The resident used her left arm to assist with putting on clothing and performing activities of daily living (ADLs) The right-sided tray table was able to be removed from the wheelchair but was			

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	supposed to be on the wheelchair when the resident was up. The resident used the table to rest her arm. CNA 4 was not aware how interventions and care requirements were communicated to the staff. Usually, the other staff told her things during their report between shifts or she could ask the nurse. During an interview, on 2/12/25 at 10:51 a.m., the Director of Nursing (DON) indicated she was not aware the resident had a tray table for her wheelchair. She did not know when it was placed on the wheelchair. During an interview, on 2/12/25 at 11:05 a.m., the DON indicated therapy put the right-sided tray table on the resident's wheelchair as a "comfort measure" when she was admitted to the facility. The resident was able to communicate with the staff regarding if she wanted the tray table on or not. Normally, the tray-table would have been added to the resident's profile, but she was unable to find documentation of this for Resident E. She was not sure if there should have been a Physician's Order. The therapy department told her they communicated the tray table intervention to the CNA on duty, but she was not sure if it was communicated to the rest of the nursing staff. During an interview, on 2/12/25 at 11:41 a.m., Registered Nurse (RN) 7 indicated Resident E used the right-sided tray table all the time. Resident E was able to remove the tray table from the wheelchair but needed assistance to put it back on. There was not an assignment sheet which included interventions such as tray tables, and the information was passed along through verbal report. During an interview, on 2/12/25 at 11:48 a.m., the			

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	DON indicated she was unable to find communication between therapy and nursing regarding the resident's right-sided tray table. There were no therapy notes pertaining to the tray table. The tray table should have been evaluated by therapy, and communicated through a communication form from therapy to nursing. Then a Physician's Order should have been obtained and the intervention added to the care plan. 3. During an observation, on 2/10/25 at 1:55 p.m., Resident F was observed up in her wheelchair with a half tray table attached to the left side of her wheelchair. The resident's left hand was contracted (permanent or prolonged shortening of muscles, tendons, ligaments, or skin that restricts range of motion and can lead to deformities). During an observation, on 2/12/25 at 11:34 a.m., Resident F was observed up in her wheelchair with the left-sided tray table in place. Resident F's record was reviewed on 2/12/25 at 11:22 a.m. An annual Minimum Data Set (MDS) assessment, dated 11/17/24, indicated the resident had moderate cognitive impairment and functional limitation in range of motion (ROM) on one side of the upper and lower extremities. Diagnoses on the resident's profile included, but were not limited to, hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. The resident's Physician's Orders lacked documentation of an order for the left-sided tray table.			

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	A care plan, last revised 12/12/24, indicated cerebrovascular (blood vessels in brain) with left hemiplegia, dysphagia (difficulty swallowing, and aphasia (language disorder affecting the ability to communicate) and was at risk for cerebrovascular complications related to cerebrovascular accident (CVA) (stroke). The care plan lacked documentation of the left-sided tray table. During an interview, on 2/12/25 at 11:37 a.m., Certified Nurse Aide (CNA) 4 indicated Resident F was able to remove the tray table from her wheelchair but needed assistance to put it back on. CNA 4 was not sure when the tray table was placed on the resident's wheelchair, but the resident had it in place since she started working at the facility. She was not sure how the nursing staff would have communicated the resident's needs to her if it was a resident she was not familiar with. The interventions, such as tray tables, were usually just communicated during a verbal report. During an interview, on 2/12/25 at 11:41 a.m., Registered Nurse (RN) 7 indicated Resident F had the left-sided tray table in place for a long time, but she was not sure exactly how long. Resident F was able to remove the tray table from the wheelchair but needed assistance to put it back on. There was not an assignment sheet which included interventions such as tray tables, and the information was passed along through verbal report. During an interview, on 2/12/25 at 12:02 p.m., the Director of Nursing (DON) indicated she was unable to find supporting documentation for Resident F's tray table, such as therapy notes, a Physician's order, or care plan.			

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	On 2/11/25 at 2:00 p.m., the DON provided a document titled, "Use of Assistive Devices," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Policy Explanation and Compliance Guidelines: 1. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat, or get dressed. Assistive devices include...e. Mobility aids...f. Orthotic or prosthetic equipment...2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care...5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. 6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed...." This citation relates to complaint IN00451478. 3.1-42(a)(2)			