**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** WINTERSONG VILLAGE  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1005 SOUTH EDGEWOOD DRIVE, KNOX, IN 46534

**ID IDENTIFICATION NUMBER:**  155283  
**PREFIX:** F  
**TAG:** 0000

**MULTIPLE CONSTRUCTION**

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<thead>
<tr>
<th>A. BUILDING</th>
<th>X2)</th>
<th>B. WING</th>
<th>X3) DATE SURVEY</th>
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<td>06/03/2019</td>
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**DATE SURVEY COMPLETED:** 06/03/2019

**STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION).Ribbon: PRELIMINARY**

- **ID:** F 0000  
  **PREFIX:** Bldg. 00  
  **TAG:** 0000
  - This visit was for a Recertification and State Licensure Survey.
  - Survey dates: May 28, 29, 30, 31, & June 3, 2019
  - Facility number: 000181  
  - Provider number: 155283  
  - AIM number: 100266860
  - Census Bed Type:  
    - SNF/NF: 26  
    - Total: 26
  - Census Payor Type:  
    - Medicare: 2  
    - Medicaid: 22  
    - Other: 2  
    - Total: 26
  These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.
  - Quality review completed on 6/5/19.

- **ID:** F 0610  
  **PREFIX:** SS=D  
  **TAG:** Bldg. 00
  - §483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation
  - §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
    - §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.
    - §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

- **TITLE:**  
- **DATE:** (X6)

---

Any deficienystatement ending with an asterisk (*) denotes a deficieny 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.
### State of Deficiencies and Plan of Correction

**Identification Number**: 155283  
**Date Survey Completed**: 06/03/2019

**Name of Provider or Supplier**: WINTERSONG VILLAGE  
**Address**: 1005 SOUTH EDGEWOOD DRIVE, KNOX, IN 46534

<table>
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<tr>
<th>ID</th>
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<th>Regulatory or LSC Identifying Information</th>
<th>Provider's Plan of Correction</th>
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<tr>
<td>F 0610</td>
<td>F610</td>
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#### Summary Statement of Deficiency

- **

#### Finding includes:

- Interview with Resident 5 on 5/28/19 at 10:10 a.m., indicated someone had taken $15 from his wallet last week without his permission. He reported to a Nurse and he could not remember the Nurse's name.

- Resident 5's record was reviewed on 5/30/19 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, pain, hypertension (high blood pressure) and depression.

- The Quarterly Minimum Data Set assessment, dated 5/28/19, indicated the resident was alert and oriented and cognitively intact for decision making.

- The allegation of the misappropriation of the resident's property was reported to ISDH (Indiana State Department of Health) on 5/22/19 when the incident was immediately reported to the Administrator. The follow up report was completed and sent to ISDH on 5/24/19, 2 days later. Per Federal guidelines, the facility had 5 days to investigate and complete the report.

- What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

- No residents were affected by this alleged deficient practice. The facility reimbursed the resident's $15 that was reported missing. Resident 5 has a lock box that was provided by the facility upon his admission and the resident keeps the key on a wrist chain. The Administrator will conduct a full investigation on all abuse allegations and interview all employees that are relative to the allegation. An Employee Interview form and Checklist form to ensure all employees have been interviewed have been implemented for future investigations.

- How other residents having the potential to be affected by the...
The follow up report indicated the Police filed a missing monies report, staff searched for the monies in the resident's room and the money was not found. Some of the staff were interviewed on 5/22/19 and 5/23/19.

Interview with the Administrator on 5/30/19 at 10:16 a.m., indicated not of the all staff was interviewed due to some of the staff were PRN (as needed). Usually, all of the staff are interviewed, especially with working different schedules and not sure exactly when the money went missing. The following staff was not interviewed as of yet: 2 night shift Nurses, 3 Dietary staff, 3 Housekeeping staff, and 6 other nursing staff (included Nurses and CNAs).

A policy titled, "Abuse & Neglect Policy", was provided by the Administrator. This current policy, indicated "...Investigation;...The investigator will review relevant documentation, including relevant parts to the medical records, and interview witnesses...."

3.1-28(d)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: WINTERSONG VILLAGE
STREET ADDRESS, CITY, STATE, ZIP CODE: 1005 SOUTH EDGEWOOD DRIVE, KNOX, IN 46534

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meetings to ensure regulatory compliance. A monitoring tool will be implemented to ensure completion of investigations. This monitoring tool will be reviewed by the Regional Director weekly for a period of six months to ensure completion.

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Monitoring will be completed by the Administrator. The Administrator will conduct a full investigation on all abuse allegations and interview all employees that are relative to the allegation. An Employee Interview form and Checklist form to ensure all employees have been interviewed have been implemented for future investigations. These forms will be used for all appropriate allegations and reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance. A monitoring tool will be implemented to ensure completion of investigations. This monitoring tool will be reviewed by the Regional Director weekly for a period of six months to ensure
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER
155283

A. BUILDING
00

X2) MULTIPLE CONSTRUCTION

B. WING

X3) DATE SURVEY COMPLETED
06/03/2019

NAME OF PROVIDER OR SUPPLIER
WINTERSONG VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE
1005 SOUTH EDGECOOD DRIVE
KNOX, IN 46534

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<th>ID</th>
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<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 0655 SS=D Bldg. 00</td>
<td>483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care</td>
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What date the Systematic changes will be completed.

7/3/2019
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>PREFIX</td>
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<tr>
<td>plan-</td>
<td>(i) Is developed within 48 hours of the resident's admission.</td>
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<td>F655</td>
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<td>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</td>
<td>07/03/2019</td>
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<tr>
<td>§483.21(a)(3)</td>
<td>The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</td>
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<td>(i) The initial goals of the resident.</td>
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<td>(ii) A summary of the resident's medications and dietary instructions.</td>
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<td>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</td>
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<td>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</td>
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<td>Based on record review and interview, the facility failed to provide in writing, to the resident, a summary of the Baseline Care Plan within 48 hours after admission into the facility for 1 of 14 resident care plans reviewed. (Resident 19)</td>
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<td>Finding includes:</td>
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<td>Resident 19's record was reviewed on 5/31/19 at 9:04 a.m. Diagnoses included, but were not limited to, cancer, renal failure and hypertension (high blood pressure).</td>
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<td>The Admission Minimum Data Set assessment, dated 4/17/19, indicated the resident was alert and oriented and cognitively intact for decision making.</td>
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<td>The Baseline Care Plan Conference, dated 4/10/19, lacked an indication that the resident was present,</td>
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<td>What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</td>
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<tr>
<td>No residents were affected by this alleged deficient practice. Resident 19 is no longer in the facility. All other baseline care plans were reviewed, and all were complete. A new baseline care plan was implemented that includes initial goals, physician orders, dietary orders, therapy services and social services. This baseline care plan will be completed by each department</td>
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<td>received a copy of the Care Plans, and understood the Baseline Care Plans.</td>
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<td>Interview with the Social Services Director (SSD) on 5/31/19 at 1:41 p.m., indicated she was unaware the resident or the resident's representative was to have received a copy of the Baseline Care Plans and to have signed the form to indicate the resident was present during the Baseline Care Plan Conference.</td>
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| A policy, titled "Care Planning," was provided on 5/31/19 at 2:38 p.m. by the SSD. This current policy indicated, ",...2. The resident and/or the resident's representative will be provided a summary of the baseline care plan to be signed by the resident or the resident representative...5. The resident and/or resident's representative are encouraged to participate into the development of the revisions to the resident's care plan...,"

3.1-35(c)(2)(c) | and reviewed with the resident or resident representative and signed within 24 hours as per facility policy. The baseline care plan for new admissions will be brought daily to IDT meetings to ensure completion. |
| How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. No other residents were affected by this alleged deficient practice. All other baseline care plans were reviewed, and all were complete. A new baseline care plan was implemented that includes initial goals, physician orders, dietary orders, therapy services and social services. This baseline care plan will be completed by each department and reviewed with the resident or resident representative and signed within 24 hours as per facility policy. The baseline care plan for new admissions will be brought daily to IDT meetings to ensure completion. |
| What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All other baseline care plans }
were reviewed, and all were complete. A new baseline care plan was implemented that includes initial goals, physician orders, dietary orders, therapy services and social services. This baseline care plan will be completed by each department and reviewed with the resident or resident representative and signed within 24 hours as per facility policy. The baseline care plan for new admissions will be brought daily to IDT meetings to ensure completion. A monitoring tool will be implemented and maintained by the Director of Nursing or designee to ensure base line care plans for new admissions are completed and signed within 24 hours as per facility policy. This monitoring tool will be maintained for all new admissions for a period of six months and reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance.

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

All other baseline care plans...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

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<td>A. BUILDING 00</td>
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**NAME OF PROVIDER OR SUPPLIER**

WINTERSONG VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1005 SOUTH EDEWOOD DRIVE

KNOX, IN 46534

**SUMMARY STATEMENT OF DEFICIENCY**

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<td>F 0689</td>
<td>SS=E</td>
<td>Bldg. 00</td>
<td>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.</td>
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**PROVIDER'S PLAN OF CORRECTION**

- were reviewed, and all were complete. A new baseline care plan was implemented that includes initial goals, physician orders, dietary orders, therapy services and social services. This baseline care plan will be completed by each department and reviewed with the resident or resident representative and signed within 24 hours as per facility policy. The baseline care plan for new admissions will be brought daily to IDT meetings to ensure completion. A monitoring tool will be implemented and maintained by the Director of Nursing or designee to ensure base line care plans for new admissions are completed and signed within 24 hours as per facility policy. This monitoring tool will be maintained for all new admissions for a period of six months and reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance.

What date the Systematic changes will be completed.

7/3/2019
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**
155283

**MULTIPLE CONSTRUCTION**
A. BUILDING
B. WING

**DATE SURVEY COMPLETED**
06/03/2019

**NAME OF PROVIDER OR SUPPLIER**
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<tr>
<td>F 0689</td>
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<td>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</td>
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<td>07/03/2019</td>
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<td>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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<td>What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</td>
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<td>Based on observation, record review, and interview, the facility failed to ensure the safety of residents related to an unlocked public restroom and a fall related to interventions not in place at the time of the fall for 1 of 1 residents reviewed for falls. The unlocked public restroom had the potential to affect 11 ambulatory residents, 2 of whom wandered and were cognitively impaired. (Public Restroom and Resident 27)</td>
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<td>No residents were affected by this alleged deficient practice. A locking door handle was placed on the restroom door preventing anyone to enter without a key. The Velcro belt was replaced on the chair for resident 27 to ensure proper fitting and safety. A Restraint Record Flowsheet has been implemented to ensure this resident's restraints are in place when in her chair.</td>
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<td>Findings include:</td>
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<td>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</td>
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<td>1. Observation on 5/28/19 at 1:45 p.m., the Public Restroom was unlocked and lacked a pull cord for assistance located in the bathroom.</td>
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<td>No other residents were affected by this alleged deficient practice. There are no other residents with a restraint at this time. A locking door handle was placed on the</td>
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<td>Observation on 5/29/19 at 8:25 a.m., the Public Restroom was unlocked and lacked a pull cord for assistance located in the bathroom.</td>
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<td>The &quot;Resident Census and Condition&quot; Form indicated there were 4 residents who were independently ambulatory and 7 residents who needed assistance or had an assistance device for ambulation.</td>
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<td>Interview with the Administrator on 5/29/19 at 11:57 a.m., indicated there used to be a key, and there should be a key to lock the door.</td>
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<td>2. Resident 27's record was reviewed on 5/28/19 at 9:53 a.m. Diagnoses included, but were not limited</td>
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to, Parkinson's disease (uncontrolled movements) and anoxic (lack of oxygen to the brain) brain damage.

The Quarterly Minimum Date Set assessment, dated 2/15/19, indicated a trunk restraint was used daily and the resident was cognitively impaired.

A "Incident/Accident Report", indicated the resident had fallen out of her wheelchair on 3/5/19 at 8:55 a.m. The root cause of the resident's fall was that she had leaned forward from her wheelchair, had flailed (due to her Parkinson's disease), her full lap tray was not in place and the Velcro belt was loose. She received a superficial abrasion to her right cheek that measured 3.8 x 3 cm (centimeters) and it healed on 4/2/19.

Care Plan for the use of the physical restraint, dated 3/9/18, indicated the physical restraints (the seatbelt and the top lap tray) were to be used due to constant uncontrolled sporadic trunk and extremities movements. Interventions were to have the physical restraints applied when the resident was up in her wheelchair and she was to have been monitored.

Interview the Director of Nursing on 5/28/19 at 9:55 a.m., indicated the CNA brought the resident out of her room in her wheelchair without securing the lap belt and without her full lap tray.

3.1-19 (u)(2)
3.1-45 (a)(1)
3.1-45 (a)(2)

to, Parkinson's disease (uncontrolled movements) and anoxic (lack of oxygen to the brain) brain damage.

restroom door preventing anyone to enter without a key. The Velcro belt was replaced on the chair for resident 27 to ensure proper fitting and safety. A Restraint Record Flowsheet has been implemented to ensure this resident's restraints are in place when in her chair.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A locking door handle was placed on the restroom door preventing anyone to enter without a key. The Velcro belt was replaced on the chair for resident 27 to ensure proper fitting and safety. A Restraint Record Flowsheet has been implemented to ensure this resident's restraints are in place when in her chair. A monitoring tool will be implemented, and the Director of Nursing or designee will monitor to ensure that nursing staff are checking the restraints and the Restraint Record Flowsheet is completed. This monitoring will take place daily X 4 weeks, then weekly X 5 months. The Restraint Record Flowsheet will be ongoing.

Interview the Director of Nursing on 5/28/19 at 9:55 a.m., indicated the CNA brought the resident out of her room in her wheelchair without securing the lap belt and without her full lap tray.

3.1-19 (u)(2)
3.1-45 (a)(1)
3.1-45 (a)(2)
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<td>155283</td>
<td>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. A locking door handle was placed on the restroom door preventing anyone to enter without a key. The Velcro belt was replaced on the chair for resident 27 to ensure proper fitting and safety. A Restraint Record Flowsheet has been implemented to ensure this resident’s restraints are in place when in her chair. A monitoring tool will be implemented, and the Director of Nursing or designee will monitor to ensure that nursing staff are checking the restraints and the Restraint Record Flowsheet is completed. This monitoring will take place daily X 4 weeks, then weekly X 5 months. The Restraint Record Flowsheet will be ongoing. This monitoring tool will be reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance. What date the Systematic changes will be completed. 7/3/2019</td>
<td>00</td>
<td>06/03/2019</td>
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### Statement of Deficiencies and Plan of Correction

**Identification Number**: 155283  
**Date Survey Completed**: 06/03/2019

**Provider or Supplier**: Wintersong Village  
**Address**: 1005 South Edgewood Drive, Knox, IN 46534

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| F 0791 | SS=D   | Bldg. 00    | 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs | §483.55 Dental Services  
The facility must assist residents in obtaining routine and 24-hour emergency dental care. |

- §483.55(b) Nursing Facilities.  
The facility-
  - §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
    - (i) Routine dental services (to the extent covered under the State plan); and
    - (ii) Emergency dental services;
  - §483.55(b)(2) Must, if necessary or if requested, assist the resident:
    - (i) In making appointments; and
    - (ii) By arranging for transportation to and from the dental services locations;
  - §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;
  - §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility’s responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility’s responsibility; and
§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.

Based on interview and record review, the facility failed to follow up on a recommendation from a dentist visit for 1 of 1 residents reviewed for dental services. (Resident 5)

Finding includes:

Interview with Resident 5 on 5/28/19 at 10:33 a.m., indicated he had a toothache every now and then, and had problems with his teeth. He had some missing teeth in the front and had not had an appointment with his dentist for the toothaches.

Resident 5's record was reviewed on 5/30/19 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, pain, hypertension (high blood pressure) and depression.

The Quarterly Minimum Data Set assessment, dated 5/28/19, indicated the resident was alert and oriented and cognitively intact for decision making.

A dentist visit note, dated 12/3/18, indicated the resident needed to be referred to an oral surgeon to extract the remaining root tips.

The record lacked a follow up on the recommendation from the dentist.

Interview with the Social Services Director (SSD) on 6/3/19 at 10:24 a.m., indicated the Nurses review the dentist notes and then follow up and schedule the appointments.

What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice?
No residents were affected by this alleged deficient practice. A dental appointment has been made for resident 5 and transportation has been scheduled. Resident 5 has had no recent complaints of pain to his mouth and he has not requested pain medication.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?
No other residents were affected by this alleged deficient practice. Recommendations have been reviewed and all other resident's appointments are scheduled including transportation.

What measures will be put into place or what systemic changes will be made to ensure that the deficient
Interview with the Director of Nursing on 6/3/19 at 11:06 a.m., indicated it was the SSD that should have reviewed the note, made the appointment and made transportation arrangements.

Interview with the SSD on 6/3/19 at 11:10 a.m., indicated she only made the transportation arrangements and there was a lack of communication with the Nursing staff.

3.1-34 (a)(1)(2)(3)

The Director of Nursing will review all recommendations and ensure that all appointments and transportation have been made. A monitoring tool will be implemented, and the Director of Nursing or designee will monitor recommendations to ensure all appointments and transportation have been made.

How the corrective actions will 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 will review all recommendations and ensure that all appointments and transportation have been made. A monitoring tool will be implemented, and the Director of Nursing or designee will monitor recommendations to ensure all appointments and transportation have been made. This monitoring will take place daily X 8 weeks, then weekly X 4 months. This monitoring tool will be reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance.
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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
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<td>F 0812</td>
<td>SS=E</td>
<td>Bldg. 00</td>
<td>483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve - Sanitary §483.60(i) Food safety requirements.</td>
<td>F 0812</td>
<td>F812</td>
<td></td>
<td>What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</td>
<td>07/03/2019</td>
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Finding includes:

- During the initial tour of the Kitchen with the
Dietary Manager on 5/28/19 at 8:50 a.m., there was an undated bag of chicken patties and a bag of hamburger patties opened and exposed to the air in the freezer.

Interview with the Dietary Manager at that time, indicated the bags should have been sealed and dated after opening.

A policy titled, "Storage of Frozen Foods," was provided by the Dietary Manager on 5/28/19 at 11:30 a.m. This current policy indicated, "...Procedure...4. Discard any thawed, frozen food with a rancid small or with off-odor, as it denotes food that has been over-stored. Additionally, any frozen food products that have torn, punctured, damaged, or partially opened packaging should be thrown away...6. Freezer burn is caused by air, which contacts the food surface...."

3.1-21 (i)(3)

Freezer were discarded immediately. All other food items were checked, and all items were sealed and dated.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.

No other residents were affected by this alleged deficient practice. The open food items in the freezer were discarded immediately. All other food items were checked, and all items were sealed and dated.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A monitoring tool will be implemented to ensure all food items are sealed and dated. The Dietary Manager or designee will conduct this monitoring daily X 8 weeks, then weekly X 4 months.

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. A monitoring tool will be implemented to ensure all food...
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<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>155283</td>
<td>items are sealed and dated. The Dietary Manager or designee will conduct this monitoring daily X 8 weeks, then weekly X 4 months. This monitoring tool will be reviewed monthly during the Quality Assurance Performance Improvement meetings to ensure regulatory compliance.</td>
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<td>What date the Systematic changes will be completed. 7/3/2019</td>
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NAME OF PROVIDER OR SUPPLIER: WINTERSONG VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1005 SOUTH EDgewood Drive, KNOX, IN 46534

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: X1) PROVIDER/SUPPLIER/CLA 155283

MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING

DATE SURVEY COMPLETED: 06/03/2019