STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155851	A. BUILDING 00 B. WING	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ORCHARD POINTE HEALTH CAMPUS	702 SAWYER ROAD KENDALLVILLE, IN 46755

(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. This visit included the Investigation of Complaint IN00399244. This visit also included a State Residential Licensure Survey. Complaint IN00399244 - Unsubstantiated due to lack of evidence. No deficiencies related to the allegations are cited. Survey dates: February 7, 8, 9, and 10, 2023 Facility number: 013704 Provider number: 155851 AIM number: 300017697 Census Bed Type: SNF/NF: 29 SNF: 9 Residential: 30 Total: 68 Census Payor Type: Medicare: 4 Medicaid: 25 Other: 39 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2023	F 0000	The submission of this plan of correction does not indicate an admission by Orchard Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents. This facility recognizes its obligation to provide legally and medically necessary care and service to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential and health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. Orchard Pointe Health Campus respectfully request from the Department a desk review for paper compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Haylee Everidge, HFA	Executive Director	02/23/2023

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.

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen tubing was properly labeled for 2 of 2 residents reviewed. (Resident 89 and Resident 19). Findings include: 1) During an observation on 2/7/23 at 2:21 PM, Resident 89 had oxygen on at 1 liter per minute (LPM) per nasal cannula (NC) (oxygen tubing used to deliver supplemental oxygen directly through the nostrils) via a portable oxygen tank. The oxygen tubing was not labeled with a date when it had been initiated/changed. During an observation on 2/8/23 at 9:44 AM, the resident had oxygen on at 1 LPM NC via a portable oxygen tank. The oxygen tubing was not labeled with a date when it had been initiated/changed. During an observation on 2/8/23 at 1:51 PM, the resident had oxygen on at 1 LPM NC via a portable oxygen tank. The oxygen tubing was not labeled with a date when it had been initiated/changed. On 2/8/23 at 2:39 PM, Resident 89's record was reviewed. Diagnoses included bilateral pleural effusion, acute respiratory failure with hypoxia,	F 0695	1. 1. Residents 89 and 19 were affected by the alleged deficient practice. At time of alleged deficient practice, both residents' oxygen tubing was replaced, labeled, and dated. 2. 2. All residents receiving supplemental oxygen had their tubing audited and care plans reviewed. In-servicing for nursing staff on Administration of Oxygen policy started and on-going until all nursing staff are educated. 3. 3. As a measure of ongoing compliance, the DHS, or designee, will complete an audit of all residents receiving supplemental oxygen as available, to ensure tubing is labeled and dated. Audit to be completed weekly for 1 month, every other week for 2 months, then monthly for 3 months. 4. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	02/28/2023

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	pulmonary fibrosis, anemia in other chronic diseases, hypertensive chronic kidney disease, type 2 diabetes mellitus, peripheral vascular disease, solitary pulmonary nodule and edema. A review of Resident 89's order, dated 2/6/23, indicated she was to be on oxygen at 1 LPM NC continuous. Her oxygen tubing was to be changed monthly on the 1st day of the month. A review of the Resident 89's admission care plan, dated 2/6/23, indicated she was on oxygen at 1 LPM NC, had potential to get short of breath when lying flat, acute respiratory failure with hypoxia and pulmonary fibrosis with a goal to be free of complications from shortness of breath. One approach to this care plan was to administer oxygen per the Medical Doctor's order and as needed. In an interview on 02/08/23 at 2:15 PM, the Director of Nursing (DON) indicated Resident 89 arrived at the facility wearing 1 liter/minute (LPM) of oxygen NC and continued to wear 1 LPM of oxygen NC. In an interview on 2/8/23 at 1:51 PM, LPN 3 indicated, Resident 89's NC tubing was oxygen tubing from when the resident was in the hospital. She indicated the oxygen tubing was not labeled with a date when initiated/changed. 2) During an observation on 2/8/23 at 1:44 PM, Resident 19 had oxygen on at 2 LPM NC via a portable oxygen tank. The oxygen tubing was not labeled with a dated when initiated/changed. On 2/9/23 at 10:30 AM, Resident 89's record was reviewed. Diagnoses included chronic obstructive pulmonary disease, acute respiratory		will be reviewed and updated as warranted. 5. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 28th, 2023.	

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	failure with hypoxia, hypertensive heart and chronic kidney disease with heart failure, paroxysmal atrial fibrillation, shortness of breath, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side, and edema. Resident 89's quarterly MDS assessment, dated 12/6/22, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, the resident was alert, oriented and interviewable. A review of Resident 19's order, dated 2/8/23, indicated he could use oxygen at 2 LPM per NC prn and his oxygen tubing was to be changed monthly on the 1st day of the month. A review of the Resident 19's care plan, last updated 2/7/23, indicated, he was on oxygen at 2 LPM per NC prn. The care plan indicated the resident had a potential to get short of breath when lying flat with a goal to be free of complications from shortness of breath. One approach to this care plan was to administer oxygen per the Medical Doctor's order and as needed. In an interview on 2/8/23 at 1:44 PM, LPN 3 indicated, Resident 19's NC oxygen tubing was not labeled with a date when initiated/changed. In an interview on 2/8/23 at 2:15 PM, the DON indicated the facility policy indicated oxygen tubing should be dated when it is initiated, changed monthly and as necessary (prn). On 2/7/23 at 2:50 PM, a current procedure titled "Administration of Oxygen", revised 12/31/22, provided by the Executive Director, indicated oxygen tubing should be dated when it was			

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	initiated and should be changed monthly and prn. 3.1-47(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure safe medication storage in 1 of 1 resident room reviewed (Resident 11). During an observation on 2/7/23 at 11:06 AM 3	F 0761	1. 1. Resident 11 was affected by the alleged deficient practice. No adverse effects noted. All noted items were removed from Resident 11's bathroom at time of alleged deficient practice. 2. 2. Room sweeps were	02/28/2023

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	packets of Stimulen advanced wound healing collagen and 2 packets of skin prep were found on the sink leaning on the back of the faucet it Resident 11's bathroom. A bottle of nystatin powder was also found on the back of the toilet in Resident 11's bathroom. During an observation on 2/8/23 at 9:27 AM with the Director of Nursing (DON), a packet of Stimulen advanced wound healing collagen and two packets of skin prep were noted on bathroom sink against the back of the faucet. The DON indicated those items should not be stored in the resident's bathroom. During a record review on 2/8/23 at 11:24 AM, the record indicated Resident 11 had diagnoses including unspecified atrial fibrillation, gastro-esophageal reflux without esophagitis, and chronic pain syndrome. A Minimum Data Set (MDS) dated 12/13/22 included a Basic Interview for Mental Status (BIMS) score of 14 out of 15, indicating she was alert and interviewable. The MDS also indicated Resident 11 had a stage 2 pressure ulcer. A physician's order dated 1/18/23 indicated collagen powder should be applied to Resident 11's coccyx wound and covered with a foam dressing after cleansing. No order for nystatin powder was available for review. During an interview on 2/7/23 at 11:06 AM, Resident 11 indicated staff had applied a powder to a rash in her groin area. A current policy titled Medication Storage in the Facility, last revised 10/19, indicated medication supplies should be accessible to only licensed facility personnel, pharmacy personnel, and		conducted for all residents to ensure no powders or dressings were stored in residents' rooms. In-servicing for nursing staff on Medication Storage policy started and on-going until all nursing staff are educated. 3. 3. As a measure of ongoing compliance, the DHS, or designee, will complete random audits of resident's rooms and bathrooms to ensure no powders or dressings are stored there. Audits will be completed on 5 residents weekly for 1 month, then every other week for 2 months, then monthly for 3 months. 4. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 28th, 2023.	

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	facility personnel lawfully authorized to administer medications. 3.1-25(m)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00399244. Survey dates: February 7, 8, 9, and 10, 2023 Facility number: 013704 Residential Census: 30 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed February 13, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by Orchard Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents. This facility recognizes its obligation to provide legally and medically necessary care and service to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential and health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. Orchard Pointe Health Campus respectfully request from the Department a desk review for paper compliance.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with			

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	applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a first aid trained staff member was present on site for 20 of 20 shifts reviewed with potential to affect 30 of 30 residents. Findings include: During an as worked schedule review conducted at 11:05 AM on 2/10/23, no first aid trained staff member was on site on February 3, 4, 5, 6, 7, 8 and 9 of 2023. During an interview with the Administrator on 2/10/23 at 11:50 AM, the Administrator indicated she was unaware each shift should have a first aid trained staff member on site.	R 0117	1. 1. All residents had the potential to be affected by the alleged deficient practice. No adverse effects noted. 2. 2. Audit completed of all nursing staff to ensure compliance of CPR and First Aid training. Audit to be completed by Scheduling Coordinator or designee to ensure upon hire that all nurses have received CPR and First Aid training. Campus collected current CPR and First Aid Certificates to update the license binder. 3. 3. As a measure of ongoing compliance, the DHS, or designee	03/17/2023

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	On 2/10/23 at 1:37 PM the Director of Nursing (DON) provided a Quality Assurance and Performance Improvement Report dated 1/6/23. The report indicated a need for Cardiopulmonary Resucitation (CPR) certifications. The DON provided a roster of employees who had completed an electronic training course titled "First Aid Refresher" dated 4/4/22. The DON indicated the course did not include a certification. She indicated no staff had first aid certifications. A current policy titled "Assisted Living Emergency Assistance Guidelines" provided by the DON on 2/10/23 at 1:37 PM indicated staff may be called upon to provide basic first aid needs.		will ensure there will be a staff member scheduled each shift with current CPR and First aid certificates. CPR and First Aid Training offered at the Campus and is scheduled for March 15th, 2023. 4. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 17th, 2023.	