STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 00 B. WING	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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: October 17, 18, 19, 20, 21 and 24, 2022 Facility number: 002982 Provider number: 155700 AIM number: 200382090 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 13 Medicaid: 25 Other: 14 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 11/1/22.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after November 23, 2022.**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Brinkman	Executive Director	11/17/2022

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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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to revise a resident's care plan to reflect new or changed interventions for 1 of 17 residents whose care plans were reviewed. (Resident 13) Finding includes: During an interview, on 10/17/2022 at 10:00 A.M., Resident 24 indicated that Resident 13 had wandered into her room. She indicated it is usually in the evening when it happens and she has yelled at her to get out of her room. Staff will then come in and will take her out. During an interview, on 10/17/2022 at 11:15 A.M., Resident 45 indicated that she had been sleeping during the night, and when she turned in her bed Resident 13 was in her room and staring at her. Resident 45 yelled at her to get out of her room and informed the nursing staff the next morning.	F 0657	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #13 – The care plan has been reviewed by the IDT team (nursing, social service, activities, dietary) and updated 10/21/22 to include person centered interventions and interventions for wandering into other resident rooms. **How other residents having the potential to be affected by the same deficient practice will be**	11/23/2022

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	During an interview, on 10/18/2022 at at 10:40 A.M., Resident 36 indicated that Resident 13 wandered into her room and moved things around. This usually occurred in the evening until the staff put Resident 13 to bed. During an interview, on 10/18/2022 at 2:15 P.M., LPN 2 indicated Resident 13 usually wandered in the evening, and staff redirected her. A Quarterly MDS (Minimum Data Set) Assessment, dated 8/4/2022, indicated Resident 13 had a BIMS (Brief Interview for Mental Status) score of 2-severly impaired cognition. She required extensive assistance of 2 staff for transfers, bed mobility and was non-ambulatory. A clinical record review was completed on 10/19/2022. Resident 13's diagnoses included, but were not limited to: dementia, psychotic disturbance and Alzheimer's disease with late onset. A care plan initiated, on 5/15/2020, indicated the resident was at risk for elopement and wandering related to disoriented to place, impaired safety awareness, and the resident the resident wanders aimlessly. Interventions included but not limited to: identify pattern of wandering: is wandering purposeful, aimless or escapist? Is resident looking for something? Does it indicate the need for more exercise? Provide structured activities: walking inside and outside, reorienting strategies including signs, pictures and memory boxes, the residents triggers for wandering are having to use restroom or prolapsed is uncomfortable. During an interview, on 10/20/2022 at 3:32 P.M., the Social Service Director indicated the residents' care plan was not person centered and had no		**identified and what corrective action(s) will be taken:** An audit for residents that are at high risk for wandering was completed. The care plans for those residents were updated as needed by the IDT team on or before 11/23/22 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff in-service will be conducted by the DNS/designee on or before 11/23/22. This in-service will include review of the facility policy related to care plans regarding residents with high risk of wandering and interventions that are person centered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The Social Service/designee will be responsible for completing the Quality Assurance and Performance Improvement Audit Tool: “Care Plans High risk Wandering” weekly for 4 weeks and then weekly for 3 months. If threshold of 90% is not met, an	

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	new interventions for wandering in other residents' rooms. On 10/21/2022 at 11:18 A.M., the Executive Director provided the policy titled "Care Planning-Interdisciplinary Team", dated 2001, and indicated the policy was the one currently used by the facility. The policy indicated "... The Interdisciplinary Team must be review and update the care plan, when the desired outcome is not met...." 3.1-35(d)(2)(b) .		action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 11/23/22.	