STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155522	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN ELWOOD, IN 46036

(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 Investigation of Complaints IN00426284 and IN00425232. Complaint IN00426284 - Federal/state deficiency related to the allegation is cited at F610 and F689. Complaint IN00425232 - Federal/state deficiency related to the allegation is cited at F610 and F689. Survey dates: January 29, 2024 Facility number: 000372 Provider number: 155522 AIM number: 100289060 Census Bed Type: SNF/NF: 67 Residential: 19 Total: 86 Census Payor Type: Medicare: 9 Medicaid: 44 Other: 14 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 5, 2024.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the resident at Elwood Health and Living. The facility requests the following plan of correction be considered its allegations of compliance.	
F 0610 SS=D 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:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Penny	Broshar	02/08/2024

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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	§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. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to conduct a thorough investigation of an injury (fracture) of unknown origin to determine a root cause (Resident B). Findings include: The clinical record for Resident B was reviewed on 1/29/24 at 10:00 a.m. Diagnoses include restless leg syndrome, osteoarthritis, cerebral aneurysm, transient cerebral ischemic attack, dysphagia, psychotic disorder with hallucinations, type 2 diabetes with diabetic neuropathy, anxiety, delusions, Alzheimer's Disease, and vascular dementia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/7/23, indicated the resident required extensive assistance for bed mobility and transfers. The resident was severely cognitively impaired. Review of the clinical record indicated the resident had a current, 1/2/24 care plan for alteration in musculoskeletal status related to fracture of the	F 0610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Any resident involved in an alleged violation of abuse, neglect, exploitation, and mistreatment including injuries of unknown source will be thoroughly investigated. Interviews will be conducted with residents (Attachment A) and Staff (Attachment B) to determine a root cause. Investigation tool (Attachment C) will also be utilized with Injury of unknown source. Copies of clinical records that record proof of injury or abuse will also be retained in investigation file. The administrator or designee will use these	02/28/2024

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	right heel. Interventions included encourage, supervise, and assist the resident, with the use of supportive devices as recommended; avoid weight bearing to right foot until healed; ice pack to right foot for 10 minutes 3 times daily; refer resident to orthopedics. Review of a progress note, dated 1/2/24 at 4:17 a.m., indicated LPN 1 indicated while applying compression stockings, a bruise and dry skin area to the right heel and outer foot were observed. The area was bleeding. The nurse applied skin prep and a dressing to the area. The physician was not notified. Review of a late entry progress note, dated 1/2/24 at 6:00 a.m., LPN 1 observed discoloration to the right heel and a dry skin area at the back of the heel. Skin prep and a foam dressing were applied. Review of a progress noted, dated 1/2/24 at 8:52 a.m., indicated during report, LPN 1 was informed that Resident B's right ankle presented with discoloration and an open area above the heel. RN 2 assessed the area and determined it appeared to be an open blister that had started draining. Dark scattered bruising was noted around the ankle. The nurse informed the NP and an orders for a STAT x-ray as well as new treatment orders were obtained. Review of the x-ray results of the right ankle, dated 1/2/24 at 1:08 p.m., indicated an acute avulsion fracture off the dorsal posterior calcaneus (heel bone). Review of the facility investigation indicated the investigation lacked staff interview, assessments and interviews of other residents, or staff education.		investigation tools to complete a summary to complete follow up for the investigation. Due to the low severity of the tag and the fact that no actual harm occurred, we are requesting paper compliance at this time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Any resident involved in an alleged violation of abuse, neglect, exploitation, and mistreatment including injuries of unknown source will be thoroughly investigated. Interviews will be conducted with residents (Attachment A) and Staff (Attachment B) to determine a root cause. Investigation tool (Attachment C) will also be utilized with Injury of unknown source. Copies of clinical records that record proof of injury or abuse will also be retained in investigation file. The administrator or designee will use these investigation tools to complete a summary to complete follow up for the investigation. Due to the low severity of the tag and the fact that no actual harm occurred, we are requesting paper	

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	During an interview on 1/29/24 at 2:45 p.m., the DON and Administrator indicated the facility did not have any further information related to the investigation. Review of the current CDC guidance for investigations indicated the following: "...GUIDANCE Facility's Investigation of Alleged Violations For all alleged violations of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source, the surveyor reviews whether the facility maintains evidence that all alleged violations are thoroughly investigated. There is no specific investigation process that the facility must follow, but the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of residents. Depending upon the type of allegation received, it is expected that the investigation would include, but is not limited to: Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents; Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies such as other investigatory agencies, and hospital or emergency room personnel; Conducting record review for pertinent information related to the alleged violation, as appropriate, such as progress notes (Nurse, social		compliance at this time. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: New investigation tools (Attachment A-C) have been developed and will be implemented immediately. These tools will be added to the investigation package involving any alleged violations of abuse, neglect, exploitation, and mistreatment including injuries of unknown source. All investigations will be reviewed in QAPI for compliance for one quarter or until 100% compliance is reached. How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE what quality assurance program will be put into place: and New investigation tools (Attachment A-C) have been developed and will be implemented immediately. These tools will be added to the investigation package involving any alleged violations of abuse, neglect, exploitation, and mistreatment including injuries of unknown source. An audit tool (Attachment D) will be completed with each investigation to ensure completeness and accuracy. All	

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	services, physician, therapist, consultants as appropriate, etc.), financial records, incident reports (if used), reports from hospital/emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies...." This citation relates to Complaints IN00426284 and IN00425232. 3.1-28(d)		investigations will be reviewed in QAPI for compliance for one quarter or until 100% compliance is reached.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to investigate a fall resulting in fracture to determine root cause and identify individualized interventions to prevent further falls (Resident C). Findings include: The clinical record for Resident C was reviewed on 1/29/24 at 11:36 a.m. Diagnoses include dementia, repeated falls and osteoarthritis. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/29/23, indicated the resident required touch assistance for walking and partial moderate assistance for transfers. The	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Falls Investigation Tool (Attachment E) has been added to the Fall Packet to cue staff to do a more thorough investigation. The DON or designee will review this form when completing the Interdisciplinary Note to ensure that the root cause is listed, as well as an appropriate intervention	02/28/2024

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	resident was severely cognitively impaired. Review of the clinical record indicated the resident had a current, 12/27/23 care plan for an actual falls on 11/10/23 12/26/23 1/16/24,dated 11/10/23. The intervention for the fall on 12/26/23 was more frequent rounding. Review of a progress note, dated 1/16/24 at 5:20 p.m., indicated Resident C sustained an unwitnessed fall. The resident was found sitting on the bathroom floor. The resident denied pain and was assessed for injuries. No injuries were found. Review of a progress note, dated 1/16/24 at 5:41 p.m. indicated the resident started complaining of left hip. The physician was in the facility to see the resident. An order for a STAT left hip x-ray was obtained. Review of the left hip x-ray results, dated 1/16/24 at 9:38 p.m., indicated an acute right femoral neck fracture. A repeat x-ray or CT was recommended. Review of a time line written by the DON, dated 1/16/24, indicated the resident had an unwitnessed fall and was sent to the hospital after the initial x-ray recommended additional imaging. The family declined surgical interventions. Review of the facility investigation indicated the investigation lacked staff interview, assessments and interviews of other residents, or staff education. During an interview on 1/29/24 at 2:45 p.m., the DON and Administrator indicated the facility did not have any further information related to the investigation.		to prevent future falls. Due to the low scope and severity of this tag, we are requesting paper compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Falls Investigation Tool (Attachment E) has been added to the Fall Packet to cue staff to do a more thorough investigation. The DON or designee will review this form when completing the Interdisciplinary Note to ensure that the root cause is listed, as well as an appropriate intervention to prevent future falls. Due to the low scope and severity of this tag, we are requesting paper compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All falls will be audited (Attachment F) by the DON or designee to ensure that each have a presumed root cause and intervention to prevent future falls. Results from this audit will be	

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	Review of an Agency for Healthcare Research and Quality training titled "Falls Prevention and Management" retrieved from https://www.ahrq.gov/patient-safety/settings/long-term-care, indicated the following: "...Once the resident's condition has been addressed, it is important to investigate the circumstances in which the fall took place. Try to notice and list everything that may have contributed to the fall, including the resident's individual risk factors, environmental factors, and factors in care or equipment. Then you need to document what you have found...." This citation relates to Complaints IN00426284 and IN00425232. 3.1-45(a)		reviewed in QAPI for one quarter or until 100% compliance is reached. Once 100% compliance is achieved, audit will be reduced to random for one quarter or until 100% compliance is reached. Once 100% compliance is reached, QAPI team can review for need to continue audit. Due to the low scope and severity of this tag, we are requesting paper compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE what quality assurance program will be put into place: and All falls will be audited (Attachment F) by the DON or designee to ensure that each have a presumed root cause and intervention to prevent future falls. Results from this audit will be reviewed in QAPI for one quarter or until 100% compliance is reached. Once 100% compliance is achieved, audit will be reduced to random for one quarter or until 100% compliance is reached. Once 100% compliance is reached, QAPI team can review for need to continue audit. Due to the low scope and severity of this tag, we are requesting paper compliance.	