STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BYRON HEALTH CENTER	1661 BEACON STREET FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 29, 30, 31, and September 1, 2022. Facility number: 000255 Provider number: 155364 AIM number:100273280 Census Bed Type: SNF/NF:89 Residential:49 Total:138 Census Payor Type: Medicare:1 Medicaid:133 Other:4 Total:138 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 7, 2022	F 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** - **R 117 – Food in Form to Meet Individual Needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents on Assisted Living/Residential had the potential to be affected by this practice. All nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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			All residents on Assisted Living/Residential had the potential to be affected by this practice. All nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **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 supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** All nursing supervisors, nurses and QMAs First Aid certification will be audited monthly (Attachment 7). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** October 1, 2022	
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns			

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	§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;			
	Based on observation, interview and record review, the facility failed to ensure behavioral interventions were initiated and documented for 1 of 1 resident reviewed. (Resident 41) During an observation on 08/31/2022 at 10:15 AM, Resident 41 was observed talking to himself about going outside, living in South Bend and God needing to be with Jehovah's witnesses. Life Enrichment Specialist 1 was sitting quietly with the resident, listening. During an observation on 8/31/22 between 11: 32 and 11:56 AM, Resident 41 was wandering in the common area talking to himself about going home and God having his back. No staff intervened to listen or to redirect him. In an interview on 08/31/22 at 10:20 AM, Life Enrichment Specialist 1 indicated he monitors Resident 41 to assist with his behavior and delusions. He indicated behavior intervention documentation was in the nursing progress notes under the behavior documented. Physician notification should be in the same note or in a note as soon as they could get to it. Resident 41's record was reviewed 8/31/22 at 11:15	F 0742	**F 742 – Treatment /Srvcs Mental/Psychosocial Concerns** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff expected to initiate and document behavioral interventions will be educated on ensuring appropriate interventions are initiated and documented for residents experiencing psychosocial distress (Attachment 1) **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who experience psychosocial distress have the potential to be affected by the deficient practice. All nursing staff expected to initiate and document behavioral interventions will be educated on ensuring appropriate interventions are initiated and	10/01/2022

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	AM. Diagnoses included schizoaffective disorder, bipolar disorder, neuroleptic Parkonsonianism, diabetes, and hypertension. Resident 41's most current MDS (Minimum Data Set) assessment dated 6-8-22 indicated his BIMS (Basic interview for Mental Status) score was 15, cognitively intact. He scored 0 on mood, indicating there were no depressive feature concerns, and 0 for behaviors. No delusions, or hallucinations were coded, as well as no behavior symptoms physical, verbal or other behavior symptoms not affecting others. No rejection of care or wandering was coded. A review of Resident 41's care plan indicated staff could attempt redirection, use reset hour after meals, after snacks or drinks, offer a weights blanket, offer activities, allow to vent, do not challenge, reapproach when becomes agitated, encourage pleasant interactions, and use consensual validation. A review of progress notes dated 7/27/22 through 8/31/22 indicated the following: On 7/27/22, Resident 41 indicated he grabbed a rifle, shot his boyfriend and a little boy. There was no documentation to indicate there had been any intervention attempted. On 8/22/22, Resident 41 was talking to himself in differing voices. stating he had raped 2 girls at a mental hospital, having daughters with 10 different women, and millions of dollars being stolen from him. There was no documentation to indicate any interventions had been attempted. On 8/23/22, Resident 41 was talking about 2 women raping him in a mental hospital, 10 million dollars had been stolen from his account at the bank, and wanting to talk to social services because the demons were telling him to. There		documented for residents experiencing psychosocial distress (Attachment 1) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit behavioral intervention and documentation for 10% of residents monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 2). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit behavioral intervention and documentation for 10% of residents monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 2). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:**	

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	was no documentation to indicate there had been any intervention attempted. On 8/26/22, Resident 41 was talking about being shot in the head and wanted Depakene. There was no documentation to indicate there had been any intervention attempted. On 8/28/22, Resident 41 was talking about sex with multiple partners, Jehovah was going to destroy everyone with 2 bombs, and Rape charges. There was no documentation to indicate there had been any intervention attempted. On 08/31/22 at 6:24 AM, Resident 41 was refusing medications, restless and delusional. There was no documentation to indicate there had been any intervention attempted. A review of the Psychiatric Nurse Practitioner notes dated 8/16/2022 indicated there were no concerns reported by staff. No change in approach was recommended as well as continued behavioral monitoring , positive reinforcement and noted changes. There was no recommendation to include interventions attempted in facility documentation. A current policy dated April 2007 titled "Behavior Assessment and Monitoring" indicated under monitoring "2. the staff will document ..... the following information about specific behavior problems: a. Preceding or precipitating factors b. interventions attempted and c. outcomes associated with interventions". 3.1-43(a)(1)		October 1, 2022	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any			

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	drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			

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	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility failed to ensure nonpharmacological interventions were utilized prior to using as needed psychotropic medication for 1 of 4 residents reviewed. (Resident 77) Findings include: Resident 77's record review began on 8/29/22 at 1:09PM, diagnosis included Alzheimer's dementia, schizoaffective disorder, major depressive disorder, unspecified psychosis, and generalized anxiety disorder. Resident 77 had a physician's order dated 5/11/22 to give Ativan 0.5mg, one tablet by mouth as needed for generalized anxiety disorder, for three months, three times a day, and must have had 3 hours between doses. An MAR (Medication Administration Record) dated July 2022 indicated Resident 77 was administered Ativan on 7/2/22, 7/6/22, 7/7/22, 7/8/22, 7/11/22, 7/12/22, 7/13/22, 7/15/22, 7/16/22, 7/19/22, 7/23/22, 7/25/22, and 7/30/22. There was no notes or documetation regarding behaviors on the above dates prior to othe administration of Ativen. Resident 77's physician's orders indicated to include interventions attempted regarding behaviors every shift. For the months of July and August 2022 there were no noted behavioral interventions on the medication administration record.	F 0758	**F 758 – Free from Unnecessary Psychotropic Medications/PRN Use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** An audit of care plans for residents with as needed psychotropic medication orders was conducted to determine that appropriate interventions were listed prior to administering medication. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents with as needed psychotropic medication order had the potential to be affected by this practice. An audit of care plans for residents with as needed psychotropic medication orders was conducted to determine that appropriate interventions were listed prior to administering medication. All nursing staff expected to initiate and document behavioral interventions and the effectiveness of interventions will be educated on ensuring appropriate interventions are	10/01/2022

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	Resident 77's progress notes indicated the following behavioral episodes in the month of July: On 7/20/22 a behavior occurred with no interventions or evaluation documented. On 7/21/22 at 3:30 AM a behavior occurred. 2 interventions were attempted, but no evaluation or response was documented. On 7/21/22 at 10:11 PM a behavior occurred, but no interventions or evaluations were documented. On 7/22/22 at 11:26 AM, a behavior occurred. No interventions or evaluations were documented. On 7/22/22 at 2:05 PM a behavior occurred, but no interventions or evaluations were documented. On 7/22/22 at 9:28 PM a behavior occurred, but no interventions or evaluation were documented. On 7/28/22 at 12:45 PM a behavior occurred, but no interventions or effectiveness were documented. On 7/29/22 at 5:54 PM, a behavior occurred, but no intervention effectiveness was documented. On 7/30/22 at 9PM indicated the resisdnet was given as needed medication, offered food, and redirected in response to a behavior, but there was no evaluation for the interventions documented. An MAR dated August 2022 indicated Ativan had been given on 8/5/22, 8/8/22, 8/9/22, 8/10/22, 8/14/22, 8/15/22, 8/16/22, 8/17/22, 8/21/22, 8/23/22, 8/26/22, 8/27/22, 8/28/22, and 8/31/22. There were no notes or indications of behaviors There was no documentation of behaviors prior to the medication Ativan being given. Resident 77's progress notes indicated the following behavioral episodes dates in the month of August:		initiated and documented for residents experiencing psychosocial distress prior to medication administration (Attachment 3). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Nursing or her designee to audit behavioral intervention and effectiveness documentation for 10% of residents with as needed psychotropic medication monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 4). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Nursing or her designee to audit behavioral intervention and effectiveness documentation for 10% of residents with as needed psychotropic medication monthly times six months to determine compliance with initiating interventions and documentation. (Attachment 4). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly	

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	On 8/14/22 at 6:07 AM a behavior was documented as having occurred much of the shift without any interventions noted. On 8/21/22 at 11:53 PM a behavior was documented with interventions of snack, fluids, toileting, and ADL's (activity of daily living) noted. No evaluation or response was documented. In an interview on 8/30/22 at 11:56 AM, RN 2 indicated Resident 77 rarely had behaviors other than frequent wandering. RN 2 indicated when the residnet was not verbally redirectable she was given Ativan as needed. In an interview on 8/31/22 at 12:08 PM, the DON (Director of Nursing) indicated interventions were to be attempted prior to administering as needed medications both psychotropics and pain. The DON indicated interventions were to be found in progress notes. A current policy and procedure titled; "Antipsychotic Medication Usage" dated 2/13/2019 was received from DON on 8/31/22 at 12:08 PM. The policy indicated ...2. The attending physician, and/or nurse practioner will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions ...4. The staff will observe, document, and report to the Attending Physician and/or Nurse Practioner information regarding the effectiveness of any interventions, including antipsychotic medications .... A current policy and procedure titled; "Administering Medications" dated 7/3/18 was received from DON on 8/31/22 at 12:08 PM. The policy indicated .... 14.. When administering PRN		meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** October 1, 2022	

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	psychotropic medication, at least 3 nonpharmacological inventions should be done prior to administering the PRN psychotropic unless there is a health and safety concern which would immediately warrant the use of a psychotropic prn being administered. Examples of nonpharmacological interventions may include but are not limited to verbal redirection, offering snacks and fluids, encouraging activity, toileting, spending 1:1 time with the resident and allowing them to voice their concerns. 3.1-48(b)(2)			
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.			
	Based on observation, interview, and record review, the facility failed to ensure recipes were followed when preparing pureed foods for 17 of 17 residents reviewed. (Resident 77, Resident 75, Resident 28, Resident 33, Resident 35, Resident 70, Resident 20, Resident 2, Resident 55, Resident 62, Resident 56, Resident 74, Resident 65, Resident 38, Resident 44, Resident 57, and Resident 1). In an interview on 8/30/22 3:22 PM, the administrator and dietary manager indicated 17 residents received pureed diets from the facility kitchen. Resident 77's record was reviewed on 9/1/22	F 0805	**F 805 – Food in Form to Meet Individual Needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents on a pureed texture order for food had the potential to be affected by this practice. All dietary staff who make pureed food will be educated on ensuring recipes are followed when preparing food (Attachment 5). **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective**	10/01/2022

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	1:40PM. Diagnoses included type 2 diabetes mellitus without complications, vitamin D deficiency, unspecified, dysphagia, oropharyngeal phase, nutritional anemia, unspecified, gastro-esophageal reflux disease without esophagitis. Dietary orders included regular diet, pureed texture, honey consistency, individual bowls, nosey cups maroon spoon for diet. Resident 75's record was reviewed on 9/1/22 1:45PM. Diagnoses included dysphagia, oropharyngeal phase, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene. Dietary orders included regular diet, pureed texture, nectar consistency, may use nosey cup, adaptive equipment: maroon spoon with every meal. Resident 28's record was reviewed on 9/1/22 1:56PM. Diagnoses included type 2 diabetes mellitus without complications, feeding difficulties, unspecified, dysphagia, oropharyngeal phase, gastritis, unspecified, with bleeding, gastrointestinal hemorrhage, unspecified, hypokalemia. Dietary orders included regular diet, pureed texture, nectar consistency, double portion at breakfast for diet order. Resident 33's record was reviewed on 9/1/22 2:04PM. Diagnoses included type 2 diabetes mellitus without complications, dysphagia, oropharyngeal phase, gastro-esophageal reflux disease without esophagitis. Dietary orders included regular diet, pureed texture, nectar consistency, may have regular chocolate milk, maroon spoon/small spoon. Resident 35's record was reviewed on 9/1/22 2:14PM. Diagnoses included dysphagia,		**action(s) will be taken.** All residents on a pureed texture order for food had the potential to be affected by this practice. All dietary staff who make pureed food will be educated on ensuring recipes are followed when preparing food (Attachment 5). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Dining Services or her designee to observe two meals weekly times six months to determine compliance with following the recipe for pureed food (Attachment 6). **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** Director of Dining Services or her designee to observe two meals weekly times six months to determine compliance with following the recipe for pureed food (Attachment 6). Any issues identified during the audit process will be addressed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.	

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	oropharyngeal phase, post gastric surgery syndromes, cerebral palsy, unspecified, spastic hemiplegic cerebral palsy. Dietary orders included regular diet, pureed texture, regular/thin consistency, double entrée/protein at meals, deep dish, spouted cup with straw see restorative program, prefers to use long handled teaspoon related to hemiplegic infantile cerebral palsy. Resident 70's record was reviewed on 9/1/22 2:23PM. Diagnoses included personal history of traumatic brain injury, vitamin D deficiency, unspecified, dysphagia, oropharyngeal phase, hypokalemia, gastro-esophageal reflux disease without esophagitis. Dietary orders included regular diet, pureed texture, nectar thick consistency, maroon spoon, divided plate. Resident 20's record was reviewed on 9/1/22 2:29PM. Diagnoses included cerebral palsy, unspecified, dysphagia, oropharyngeal phase. Dietary orders included regular diet, pureed texture, nectar consistency, may have regular consistency carbonated drinks, to be upright for meals and 20 minutes following all intakes, maroon spoon for diet. Resident 2's record was reviewed on 9/1/22 2:40PM. Diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, hypermagnesemia, dysphagia, oropharyngeal phase, hypokalemia, personal history of other malignant neoplasm of large intestine, acquired absence of other specified parts of digestive tract. Dietary orders included regular diet, pureed texture, regular/thin consistency, may have mechanical soft snacks with distant supervision, maroon spoon, divided dish.		**By what date the systemic changes will be completed:** October 1, 2022	

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Resident 55's record was reviewed on 9/1/22 4:14PM. Diagnoses included type 2 diabetes mellitus without complications, vitamin D deficiency, unspecified, dysphagia, oral phase. Dietary orders included regular diet, pureed texture, regular/thin consistency, individual bowls, double portions, may have mechanical soft snacks with supervision for diet order.

Resident 62's record was reviewed on 9/1/22 4:18PM. Diagnoses included personal history of traumatic brain injury, traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter, other symptoms and signs involving the musculoskeletal system, other symptoms and signs involving the nervous system, vitamin D deficiency, unspecified. Dietary orders included regular diet, pureed texture, regular/thin consistency, double portions of entrée/protein at meals for weight loss and varied intakes.

Resident 56's record was reviewed on 9/1/22 4:27PM. Diagnoses included, dysphagia, oropharyngeal phase. Dietary orders included regular diet, pureed texture, nectar consistency.

Resident 74's record was reviewed on 9/1/22 4:33PM. Diagnoses included nutritional anemia, unspecified, dysphagia, oral phase, personal history of peptic ulcer disease, vitamin D deficiency. Dietary orders included regular diet, pureed texture, regular/thin consistency.

Resident 65's record was reviewed on 9/1/22 4:36PM. Diagnoses included dysphagia, oral phase. Dietary orders included regular diet, pureed texture, regular/thin consistency.

Resident 38's record was reviewed on 9/1/22

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4:38PM. Diagnoses included type 2 diabetes mellitus without complications, gastrointestinal hemorrhage, unspecified, vitamin D deficiency, unspecified, dysphagia, oral phase, disorders of magnesium metabolism, unspecified, hypo-osmolarity and hyponatremia, hypokalemia, gastro-esophageal reflux disease without esophagitis. Dietary orders included regular diet, pureed texture, regular/thin consistency.

Resident 44's record was reviewed on 9/1/22 4:44PM. Diagnoses included, dysphagia, oropharyngeal phase, hypokalemia. Dietary orders included regular diet, pureed texture, pudding consistency.

Resident 57's record was reviewed on 9/1/22 4:47PM. Diagnoses included, dysphagia, oropharyngeal phase, hypo-osmolarity and hyponatremia, hypokalemia. Dietary orders included regular diet, pureed texture, nectar consistency, sit upright during oral intake, remain upright for 30 minutes following oral intake, spouted cup, position upright in wheelchair, bed, no straws, staff to assist with eating.

Resident 1's record was reviewed on 9/1/22 4:53PM. Diagnoses included Parkinson's disease, hypokalemia, vitamin D deficiency, unspecified, gastro-esophageal reflux disease without esophagitis, dysphagia, oropharyngeal phase. Dietary orders included regular diet, pureed texture, nectar consistency, may have regular consistency for chocolate milk.

During an interview on 8/29/22 at 11:36AM, Cook 3 indicated she was preparing pureed beef and noodles for 23 residents, 23-25 servings. Cook 3 indicated she had a guide to tell her the number of residents on each hall that received pureed food.

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	She would measure, using the # (number) 6 scoop, the number of servings needed to serve the residents on a hall and place it in a metal pan, cover the pan and place in the warmer for delivery to the hall. Cook 3 indicated she had already prepared some beef and noodles. Cook 3 indicated she had prepared mashed potatoes, and she "followed the instructions on the box". During an observation on 8/29/22 at 11:43PM, Cook 3 used a plastic pitcher like scoop, placed 3 scoops of previously prepared beef and noodles into a robot coupe (device that chops and blends food). She added brown colored liquid from a large glass measuring cup to the beef and noodles in the robot coupe. Cook 3 indicated that she estimated she had added "about ½ cup of broth." She turned on the robot coupe to blend the food, added additional broth which she estimated was "about 1/8 cup" and turned on the robot coupe to blend the food. Cook 3 added the remaining broth from the measuring cup, she estimated "about 1/8 cup" and blended the beef and noodle mixture until smooth. Cook 3 measured 5 scoops, using a # 6 scoop, into a metal pan, covered the pan with plastic wrap and placed the metal pan in a warmer. Cook 3 removed her gloves and washed her hands. Cook 3 retrieved a clean bowl for the robot coupe. She donned clean gloves, added previously prepared green beans with liquid, contained in a small metal serving table pan, to the robot coupe bowl. Cook 3 was unable to verbalize the amount of green beans and liquid she added to the robot coupe bowl. "I just put the green beans in with the liquid from the beans". Cook 3 turned on the robot coupe to blend the beans until smooth, then added 2 tablespoons of thickener, measured with a measured tablespoon. Cook 3 turned on the robot coupe, blended the green beans, added 1 tablespoon of thickener and			

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blended the green beans again. She indicated she didn't want the puree too thick or thin, she knew the right consistency by doing it for years, and how the food dripped off the spoon.

In an interview on 8/29/22 at 12:01 PM, the Dietary Manager indicated recipes for preparing pureed foods were available in a binder. The binder was located on the preparation table near where the Dietary Manager was standing during the observation.

In an interview on 8/29/22 at 4:28PM, Cook 4 indicated she had already pureed food for the evening meal. Cook 4 indicated, for the hall they were currently serving, she prepared 11 hotdogs. She indicated she added 11 hotdogs to the robot coupe, added about 8 "ounces of water, I eyeballed it". Cook 4 indicated she made mashed potatoes, replacement for French fries on a pureed diet, added water and butter to potato flakes according to the instructions on the box. Cook 4 indicated she prepared the vegetable by adding a little amount of water, did not pay attention to the amount, "see the right consistency". She indicated she knew the consistency was right when "it looked like baby food, not too thick or thin". Cook 4 indicated a chart was available with different consistencies, she used it sometimes.

A current recipe, titled beef and noodles pureed thick, was received from the Dietary Manager on 8/29/22. The recipe indicated 20 #8 scoop portions. Ingredients included beef and noodles 20 8-ounce ladle, low sodium beef base 1 1/3 tablespoon, hot water 1-quart ½ cup, food thickener 1 cup. Instructions included " ...1. Measure portions requires from the regular prepared recipe. 2. Place in food processor and process until fine in consistency. 3. Combine hot

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broth and thickener and gradually add while processing, until a smooth consistency. All broth may not be required. 4. Scrape down sides of processor with a rubber spatula and process for 30 seconds. Allow mixture to thicken 60 seconds: it will be thick enough to hold its own shape ...."

A current recipe, titled Mashed Potatoes Instant Prep (Granule) USDA, was received from the Dietary Manager on 8/29/22 at 12:15 PM. The recipe indicated 50 #8 scoop portions. Ingredients included hot water 3 ½ quart, skim milk 1-quart ¾ cup, potato granules 2 pound 1 ounce, unsalted butter ¾ cup, salt 1 tablespoon. Instructions included " ...1. Pour water and milk into mixer bowl. 2. Add instant potato granules, margarine or butter, and salt. 3. Mix ½ minute to moisten potatoes. Beat an additional 1 minute until fluffy. (Use of a mixer is recommended) ....". A specific recipe for pureed mashed potatoes was not provided.

A current recipe, titled Beans Green Canned Pureed Thick, was received from the Administrator on 8/30/22 at 3:22 PM. The recipe indicated 1 #16 scoop portion. Ingredients included canned green beans ½ cup, margarine 1 ¼ teaspoon, food thickener 3/8 teaspoon. Instructions included " ... 1. Remove portions required from the regular prepared vegetable (drain liquid). 2. Add drained vegetables with melted margarine to food processor and process until smooth in texture. 3. Add a food thickener. Process briefly until mixed, scraping sides of bowl ....".

A current recipe, titled Hot Dog Coney Island Pureed Thick, was received from the Administrator on 8/30/22 at 3:22PM. The recipe indicated 1 each portion. Ingredients included

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	franks beef 5# 1 each, canned chili without beans 1 tablespoon, shredded mild cheddar cheese 2 tablespoon, hot water 1/3 cup 1 tablespoon, beef base 3/8 teaspoon, food thickener 1 1/4 teaspoon, pureed bread 2 2/3" slice. Instructions included " ... 1. Gather ingredients to prepare pureed sandwich. 2. Add meat/cheese/condiments etc. (exclude bread) to a food processor and process until fine in consistency. 3. Add base to hot water and gradually add to mixture while processing to a smooth homogenous consistency. 4. Add food thickener and process briefly until mixed. Scrape down sides of processor with a rubber spatula and process for 30 seconds ....". "Note: Measurements of liquid and food thickener may be adjusted to achieve desired consistency". A current recipe, titled Vegetable Blend Mixed Pureed Thick, was received from the Administrator on 8/30/22. The recipe indicated 1 #16 scoop portion. Ingredients included mixed vegetable blend ½ cup, margarine 1 ¼ teaspoon, food thickener 3/8 teaspoon. Instructions included " ... 1. Remove portions required from the regular prepared vegetable (drain liquid). 2. Add drained vegetables with melted margarine to food processor and process until smooth in texture. 3. Add a food thickener. Process briefly until mixed, scraping sides of bowl ....". In an interview on 8/30/22 at 2:47 PM, the Administrator indicated there was no specific policy regarding how to prepare pureed food, that was included in the therapeutic diet policy which indicated follow the recipe. She indicated the recipe is not exact science, staff looked at the consistency of the food. The Administrator indicated the facility had no choking issues or taste issues with residents on pureed diets. She indicated 2 staff members check the taste, quality,			

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and homogenous consistency. 17 residents received pureed diets, extra portions were made for those receiving large portions, double protein. She indicated a recipe was followed to make the food for the whole facility then food was taken to puree for those on a pureed diet. The Dietary Manager was present during the interview but did not speak.

In an interview on 9/1/22 at 9:08AM, the Chief Executive Officer indicated she had spoken with the dietary staff. She indicated they had measured the beef and noodles, added liquid to thicken and hold shape. She provided a recipe, titled Beef and Noodles Pureed Thick, highlighted instructions " ...3. Combine hot broth and food thickener and gradually add while processing, until a smooth consistency. All liquid may not be required ... it will be thick enough to hold its own shape ...".

In an interview on 9/1/22 at 10:42 AM, the Dietician indicated staff should follow the spreadsheet instructions (recipe) when preparing pureed food, make sure to have the right serving size, and amounts. Food amounts and specific amounts of liquid were on the spreadsheets in a binder. Staff were to look at the texture of the food when done but follow the recipe. The Dietician indicated some foods, beef and noodles for example, had some flexibility in adding liquid due to the type of food but staff should still be following a recipe. He indicated nutritional value of the food could be altered if too much or too little liquid is added. Staff should follow the spreadsheets as written.

A current policy, titled Therapeutic Diets, dated 11/21/2021, was received from the Administrator on 8/30/2022 at 8:32 AM. The policy included a

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	policy statement " ...Therapeutic diets shall be prescribed by the attending physician ....". Policy interpretation and implementation included " ... 1. Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered "therapeutic diets." This includes mechanical soft and pureed textures as well as honey, nectar, and pudding thick liquids. 2. A therapeutic diet must be prescribed by the resident's attending physician. The physician's diet order should match the terminology used by food services. 4. Routine menus (without therapeutic purpose) are planned by the Food Service Manager and approved by a Registered Dietician for nutritional adequacy. The regular menu will be modified by the Registered Dietician for therapeutic diets, with input from the Dietary Manager for feasibility of kitchen production. 7. Residents on therapeutic diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the attending physician in conjunction with the Clinical Dietician ....". The policy did not include how pureed food is to be prepared. 1.3-21(a)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates:August 29, 30, 31, and September 1, 2022. Facility number: 000255 Residential Census: 49	R 0000	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	

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	This State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 7, 2022		facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** - **R 117 – Food in Form to Meet Individual Needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents on Assisted Living/Residential had the potential to be affected by this practice. All nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents on Assisted Living/Residential had the potential to be affected by this practice. All nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **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 supervisors, nurses and QMAs on Assisted Living will	

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			be First Aid certified. **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** All nursing supervisors, nurses and QMAs First Aid certification will be audited monthly (Attachment 7). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. **By what date the systemic changes will be completed:** October 1, 2022	
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 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			

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	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 interview and record review the facility failed to ensure there were First Aide Certified staff in the building for all shifts. 49 residents resided in the facility. Findings include: The Employee Records Form dated 8/23/22 - 8/29/22 was provided by the Administrator on 8/30/22 at 11 AM. The Employee Records Form indicated there was no First Aide Certified staff scheduled on the following dates: 8/23/22: 1st, 2nd, 3rd shift 8/24/22: 1st, 2nd, 3rd shift 8/25/22: 1st, 2nd, 3rd shift 8/26/22: 3rd shift 8/27/22: 3rd shift 8/28/22: 2nd & 3rd shift 8/29/22: 2nd & 3rd shift In an interview with the Chief Executive Officer (CEO) on 9/1/22 at 2 PM, the CEO indicated there was not other First Aide Certified Staff scheduled 8/23/22 - 8/29/22. The CEO also indicated the facility did not have a policy but would create a policy.	R 0117	This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it. **We are asking for Paper Compliance. Thank you.** - **R 117 – Food in Form to Meet Individual Needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents on Assisted Living/Residential had the potential to be affected by this practice. All	10/01/2022

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			nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents on Assisted Living/Residential had the potential to be affected by this practice. All nursing supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **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 supervisors, nurses and QMAs on Assisted Living will be First Aid certified. **Please specify how the QAPI Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?** All nursing supervisors, nurses and QMAs First Aid certification will be audited monthly (Attachment 7). Any issues identified during the audit process will be addressed. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.	

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