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	01/26/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a Residential State Licensure survey. Survey dates: January 22, 24, 25, and 26, 2024. Facility number: 013704 Provider number: 155851 AIM number: 300017697 Census Bed Type: SNF: 17 SNF/NF: 30 Residential: 28 Total: 75 Census Payor Type: Medicare: 7 Medicaid: 30 Other: 10 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 29, 2024	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 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Haylee Everidge, HFA	Executive Director	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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	the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F)			

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	of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 0622	1 1. Resident 26 was affected	01/31/2024

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	Based on interview and record review the facility failed to ensure documentation requirements for transfer or discharge were met for 1 of 5 residents reviewed (Resident 26). Findings include: Resident 26's record was reviewed on 1/22/24 at 1:43 PM. Diagnoses included diffuse large B-cell lymphoma, unspecified site, neoplasm of uncertain behavior of the parotid salivary glands and acquired hemolytic anemia, unspecified. A review of Resident 26's current quarterly Minimum Data Set (MDS) dated 12/8/23 indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). An MDS dated 9/19/23 indicated Resident 26 had been discharged from the facility with a return anticipated. A review of progress notes dated 9/19/23 at 11:20 AM indicated Resident 26 went to a physician's office for an appointment. The next chronological progress note entry dated 9/23/23 at 9:23 PM indicated Resident 26 had returned from a hospital stay. No documentation of Resident 26's condition, documents sent, or report given was available for review. A review of a Notice of Transfer and Discharge form dated 9/19/23 indicated Resident 26 had been discharged to another health facility because her health had improved sufficiently, and she no longer needed the services provided by the facility. There was no indication on the transfer form the residnet had been transferred to the hospital.		by the alleged deficient practice. No adverse effects noted. At time of alleged deficient practice, resident was no longer receiving outside chemo treatments. 2 2. All residents receiving outside scheduled treatments have the potential to be affected. Resident 26's care plans were reviewed. Education was provided to all licensed nursing staff on transfer and discharge policy on 1/31/2024. 3 3. As a measure of ongoing compliance, the DHS, or designee will complete random audit of transferred or discharge residents to ensure accurate documentation of the transfer or discharge in the medical chart. Random audit to be completed daily in CCM x 1 month, One time per week x 2 months, Bi-Weekly x 2 months, 1 time a month x 1 month. 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 January 31, 2024.	

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	An MDS dated 10/12/23 indicated Resident 26 had been discharged from the facility with a return anticipated. A review of progress notes dated 10/11/23 at 3:52 PM indicated Resident 26 had a large BM that day. There was no indication the residnet had been sent to the hospital. The next chronological progress note entry dated 10/19/23 at 9:40 PM indicated Resident 26 had returned from a hospital stay. No documentation of Resident 26's condition, documents sent, or report given was available for review. A review of a Notice of Transfer and Discharge form dated 10/12/23 indicated Resident 26 had been discharged to another health facility because her health had improved sufficiently, and she no longer needed the services provided by the facility. There was no indication in the form the residnet had been sent to the hospital. In an interview on 1/24/24 at 1:43 PM, the Clinical Support Nurse (CSN) indicated nursing staff should document transfers from the facility in the medical record. She indicated documentation should include notification of family, assessment of current condition, report given to receiving facility staff, and any other pertinent information. She indicated the information should be found in progress notes, observations, or the event section of the medical record. During a record review conducted with the CSN on 1/24/23 at 1:50 PM, she indicated she was unable to find any discharge documentation in the progress notes, observations, or event section of the EMR for Resident 26 on 9/19/23 or 10/12/23.			

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	A current policy dated 7/11/23 provided by the CSN on 1/26/24 at 9:11 AM indicated nursing staff should document information regarding the transfer in the medical record. The policy indicated a discharge summary should be completed with a copy printed, signed, and scanned into the medical record. 3.1-12(a) 3			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview the facility failed to ensure a resident's ted hose were on every morning per physician's order for 1 of 2 reviewed. (Resident 1). Findings include: During an observation on 1/22/24 at 11:25 AM Resident 1 was not wearing her TED hose on either leg. During an observation on 1/25/24 at 10:53 AM Resident 1 was not wearing her TED hose on either leg. During an observation on 1/26/24 at 9:26 AM Resident was not wearing her TED hose on either leg.	F 0684	1 1. Resident 1 was affected by the alleged deficient practice. No adverse effects noted. Residents care plans and orders were updated and reviewed at time of alleged deficient practice. 2 2. Chart reviews were conducted for all-like residents to ensure all orders and treatments were active and appropriate. MD / NP were notified for any order clarifications. Education was provided to all licensed nursing staff on accuracy of order entry, flow sheets and nursing tasks on 1/31/2024. 3 3. As a measure of ongoing compliance, the DHS, or	01/31/2024

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	During an observation on 1/26/24 at 11:45 AM Resident was not wearing her TED hose on either leg. Resident 1's record was reviewed on 01/22/24 1:30 PM, diagnoses included a history of traumatic brain injury, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, and a history of venous thrombosis and embolism. Resident 1's current quarterly Minimum Data Set (MDS), dated 12/13/23, indicated her Basic Interview for Mental Status (BIMS) score was a 9 (moderate cognitive impairment). The MDS indicated the resident required substantial/maximal assistance (helper does more than half the effort) when lower body dressing and putting on and taking off footwear (socks, shoes, and other footwear). A Physician order dated 3/6/19 indicated bilateral TED hose were to be applied to the Resident 1's lower extremities (legs) every morning between 6:00 AM and 10:00 AM. There was no indication what time the TED hose were to be removed. Resident 1's current care plan titled pertinent ADLs (Activities of Daily Living) indicated the resident required staff assistance to complete ADL tasks completely and safely. The care plan indicated Resident 1 would complete ADL tasks completely and safely with a goal date 3/24/24. Interventions did not include applying bilateral TED hose to the resident's lower legs every morning. Resident 1's current care plan titled pertinent ADLs (Activities of Daily Living) indicated the		designee, will complete random observation of residents who have TED Hose orders for placement and documentation Daily x 8 weeks, 2 times a week x 8 weeks, and 1 time a week x 8 weeks. 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 January 31, 2024.	

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	resident had a potential for decline in ADL's related to chronic pain, dementia, a traumatic brain injury, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, osteoporosis, seizures, a history of venous thrombosis and embolism, constipation, rash, cough, and dermatitis. The care plan indicated Resident 1 would be free of an ADL decline with a goal date 3/24/24. Interventions did not include applying bilateral TED hose to the resident's lower legs every morning. The Medication Administration Record (MAR) dated 1/1/24 - 1/26/24, indicated no documentation by nursing staff Resident 1's TED hose being applied or refusal by the resident every morning between 6:00 AM - 10:00 AM. The Treatment Administration Record (TAR) dated 1/1/24 - 1/26/24, indicated no documentation of Resident 1's TED hose being applied or refusal by the resident every morning between 6:00 AM - 10:00 AM. Progress notes dated 1/1/24 to 1/26/24, received 1/26/24 at 10:30 AM, indicated no documentation by nursing staff of Resident 1's TED hose being applied or refusal by the resident every morning between 6:00 AM - 10:00 AM. In an interview on 1/26/24 at 9:26 AM, QMA 1 indicated Resident 1 was not wearing TED hose. In an interview on 1/26/24 at 9:32 AM, RN 2 indicated the night shift puts on Resident 1's TED hose. A current policy, reviewed 12/31/23, titled Guidelines for Physician Services, provided by the			

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	Clinical Support Nurse on 1/26/24 at 10:30 AM, indicated physician orders should be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act - federal act setting standards of how care should be provided to nursing home residents) and campus policy. 3.1-37			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This survey included a Recertification and State Licensure Survey. Survey dates: January 22, 24, 25, and 26, 2024. Facility number: 013704 Residential Census: 28 Orchard Pointe Heath Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed January 29, 2024	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.	