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	04/22/2024

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

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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: April 15, 16, 17, 18, 19, and 22, 2024. Facility number: 000372 Provider number: 155531 AIM number: 100289060 Census Bed Type: SNF/NF: 62 Residential: 17 Total: 79 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 14 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 1, 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 residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical			

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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	condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to identify a pressure injury and implement interventions to promote healing (Resident 115) and failed to implement an ordered treatment (Resident 24) for pressure injury for 2 of 4 residents reviewed for pressure injuries. (Residents 115 and 24) Findings include: During an interview, on 4/16/24 at 9:30 a.m., Resident 115 sat in a wheelchair in her room and indicated she had painful sores on her bottom. During an interview, on 4/17/24 at 10:05 a.m., the resident sat in a wheelchair in her room, crying. She indicated she wanted to go back to bed because her bottom was sore, and she hurt all over. During an observation, on 4/17/24 at 2:22 p.m., the resident sat in a wheelchair in her room. During a wound observation, on 4/18/24 at 10:57 a.m., a ladybug-sized wound, with a depth slightly greater than a pencil tip, was present to Resident 115's inner left gluteal area. The wound bed had a small amount of yellow tissue and the edges were rolled. Resident 115's record was reviewed on 4/19/24 at 11:32 a.m. Diagnoses included type 2 diabetes mellitus, muscle weakness (generalized), need for	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **2 residents were found to be affected by this deficient practice. Treatments are in place and are being completed for the residents identified. Skin Sweeps were performed to ensure that no other skin areas were not already captured and reported to MD for treatment.** **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. Skin sweeps were completed to ensure there were no undocumented wounds. Education was provided to all nursing staff on how to correctly input all treatment orders. The DON or designee will audit all treatment orders to ensure that all were assigned to the TAR to**	05/20/2024

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	assistance with personal care, other abnormalities of gait and mobility, and depression. The current physician orders included, but were not limited to, clean open area to left inner gluteal with normal saline. Pat dry. Apply house barrier cream to periwound (area around the wound). Apply antimicrobial wound gel to wound bed and cover with foam dressing. Change every other day and as needed for open area to left gluteal. Change for soilage/displacement (4/18/24). An admission, 4/11/24, Minimum Data Set (MDS) assessment indicated Resident 115 was cognitively intact and dependent on staff for toileting hygiene, showering/bathing, upper and lower body dressing, putting on footwear, and personal hygiene. She required substantial/maximal assistance to roll left and right, moving from sitting to lying position, and from lying to sitting position. The resident was at risk for a pressure injury and did not have unhealed pressure injuries. A current care plan, initiated 3/22/24 and revised 4/18/24, indicated the resident had a potential for impairment to the skin integrity related to impaired mobility, incontinence and admitted with moisture-associated skin damage (MASD). On 4/18/24, the resident had a stage 3 pressure injury (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer) to the left inner gluteal area. Interventions included daily skin checks with care and report new areas to nurse (3/27/24). A consultant wound assessment and plan note, dated 4/10/24, indicated the resident was admitted back from the hospital with MASD from occasional incontinence. Wound care was		**ensure treatments are being completed.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Skin sweeps were completed to ensure there were no undocumented wounds. Education was provided to all nursing staff on how to correctly input all treatment orders. The DON will audit all treatment orders to ensure that all were assigned to the TAR to ensure treatments are being completed. Audits will be completed daily (M-F) for one quarter or until 100% compliance is reached.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place? Skin sweeps were completed to ensure there were no undocumented wounds. Education was provided to all nursing staff on how to correctly input all treatment orders. The DON will audit all treatment orders to ensure that all were assigned to the TAR to ensure treatments are being completed. Audits will be completed daily (M-F) for one**	

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	ordered as follows: Cleanse wound with normal saline or sterile water. Apply zinc and antifungal powder to wound bed and cover with clean dry foam dressing every day and as needed. A nurses note, dated 4/10/24 at 2:45 p.m., indicated the resident was seen by the wound consultant and a new order was received for treatment to MASD area on bilateral buttocks. A nurses note, dated 4/16/24 at 1:44 p.m., indicated a skin sweep was completed. Treatment continued to the MASD are on bilateral buttocks. A nurses note, dated 4/18/24 at 9:25 a.m., indicated a new wound was identified during morning care. The wound measured 1.0 cm (centimeter) long by 0.8 cm wide by 0.3 cm deep. The wound bed was pink/red. The center of the wound had a slightly yellow discoloration with scant amount of serous (clear to yellow) fluid. The wound margins had epibole (rolled wound edges). During an interview, on 4/18/24 at 10:57 a.m., RN 6 indicated the area was new to Resident 115's buttock and had appeared "overnight". The resident had MASD prior to having the wound. During an interview, on 4/18/24 at 11:17 a.m., RN 6 indicated she did Resident 115's treatment to the left gluteal area the prior day and did not see the complete area. She had applied barrier cream to the wound, but had not completely wiped off the old barrier cream, so she was unable to see the wound bed. During an interview, on 4/19/24 at 10:36 a.m., CNA 7 indicated the "sore" on Resident 115's buttock was worse today than the last time she saw it a couple of weeks ago. The resident was turned		**quarter or until 100% compliance is reached. QAPI committee will review for need to continue audit after compliance is reached.**	

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onto her sides if she was comfortable with it, but was not always comfortable with rolling on her sides.

During an interview, on 4/19/24 at 11:53 a.m., LPN 8 indicated when the resident was first admitted, she had wounds on her bottom. When the resident came back from the hospital, she had an open area on her buttock.

During an interview, on 4/19/24 at 2:32 p.m., the DON indicated she had asked about the resident's open area on 4/15/24. The staff had told her it was closed. The rolled edges to the wound would indicate the area had been there longer than overnight. During an observation on 4/17/24 at 8:52 a.m., Resident 24 was laying on his back in his bed. His knees were slightly bent, falling outwards, and his feet were rolled out, resting on his ankles.

The resident was observed in the same position on the following dates and times: 4/17/24 at 9:54 a.m., 4/17/24 at 10:54 a.m., 4/18/24 at 9:00 a.m., and 4/18/24 at 10:02 a.m.

Resident 24's clinical record was reviewed on 4/17/24 at 8:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, congestive heart failure, non-Alzheimer's dementia, and coronary artery disease.

A quarterly Minimum Data Set (MDS) assessment, dated 2/11/24, indicated Resident 24 was severely cognitively impaired was dependent on staff for toileting, dressing, transferring, rolling left to right, and showering/bathing. The resident was at risk for developing pressure ulcers.

A current physician's order, dated 2/6/24 at 2:00

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	p.m., indicated preventative skin assessments to be performed every evening shift. A current physician's order, dated 4/10/24, at 8:00 a.m., indicated a foam dressing was to be applied to the left ankle daily until healed. A progress note, dated 1/11/24 at 5:56 p.m., indicated a new wound alert for a reddened area on the left ankle. No measurements were documented. The wound received immediate treatment of a foam dressing application. A progress note, dated 4/2/24 at 8:25 p.m., indicated a stage 1 pressure wound (Intact skin with a localized area of non-blanchable redness) to the left ankle. The wound was measured as 1 cm length x 1 cm width and pink in color. During an interview with RN 6 on 4/18/24 at 10:07 a.m., she indicated there was no wound on the resident's left ankle. During an observation, on 4/18/24 at 11:07 a.m., the DON checked for a dressing on the resident's left ankle. There was a dressing present, dated 4/11/24. The DON indicated the order for the foam dressing had been put into the clinical record incorrectly. This resulted in the dressing not being changed since the order had been put in on 4/10/24. She did not know how the wound and/or dressing were missed during daily preventative skin assessments. A current, undated facility policy, provided by the DON on 4/19/24 at 3:11 p.m.., titled "Wound Care Program," indicated " ...Nursing staff will employ preventative measures to successfully manage skin integrity of those resident who are identified to be at risk ...When a wound/rash is found, if			

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	identified by non-licensed personnel, the resident's nurse will be notified immediately. This nurse is responsible to do a wound/skin interruption assessment on the affected area, chart this, notify the MD/NP, get treatment orders, and notify the family ...Charting Parameters for any wound will include: ... 2. Wound dimensions: Length x Width x Depth ...6. The condition of the wound margins ...10. If the wound is a pressure injury, or has a pressure injury component, it must be staged according to the current National Pressure Ulcer Advisory Panel (NPUAP) guidelines .... Weekly follow ups by the wound nurse and or designee (primary care nurse) should be completed on any open wounds ..." 3.1-40(a)(1) 3.1-40(a)(2)			
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 observation, interview, and record review, the facility failed to provide adequate supervision and implement resident-specific interventions to prevent a fall resulting in a fracture for 1 of 5 residents reviewed for falls. (Resident 22) Finding includes:	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **One resident was found to be affected by this deficient practice. All staff was provided**	05/20/2024

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	During an observation, on 4/15/24 at 11:18 a.m., Resident 22 was lying in bed in a low position with a mat on the floor. During an observation, on 4/17/24 at 9:55 a.m., the resident was lying in a low bed, with the head of the bed up and a mat on the floor next to the bed. During an observation, on 4/18/24 at 2:57 p.m., the resident was lying in a low bed, with the head of the bed up and a mat on the floor next to the bed. Resident 22's record was reviewed on 4/18/24 at 9:04 a.m. Diagnoses included unsteadiness on feet, muscle weakness, repeated falls, unspecified abnormalities of gait and mobility, history of falling, chronic pain, generalized anxiety disorder, and dementia. Physician orders included, but were not limited to, alprazolam 0.5 mg (anti-anxiety) three times a day for anxiety (12/12/23), duloxetine 60 mg (anti-depressant) two times a day for chronic pain syndrome (12/6/23), gabapentin 300 mg (nerve medication) two times a day for chronic pain syndrome (12/6/23), furosemide 20 mg (water pill) daily for edema (swelling) (12/13/23), and quetiapine fumarate 25 mg (anti-psychotic) daily at bedtime for delusional disorders (initiated 1/30/24 and discontinued 3/21/24). A 12/12/24, admission, Minimum Data Set (MDS) assessment indicated Resident 22 was moderately cognitively impaired. The resident required substantial/maximal assistance with toileting hygiene, showering/bathing, putting on/taking off footwear, and personal hygiene. The resident required partial/moderate assistance with upper and lower body dressing. The resident required partial/moderate assistance to roll left to right,		**education at the April All Staff inservice on what interventions were appropriate for falls, with emphasis on what intentional rounding and increased rounding means. All staff were also shown how to use the KARDEX on PointClick Care to look up interventions for careplanned issues with residents.** **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 had the potential to be affected by this deficient practice. All staff was provided education at the April All Staff inservice on what interventions were appropriate for falls, with emphasis on what intentional rounding and increased rounding means. All staff were also shown how to use the KARDEX on PointClick Care to look up interventions for careplanned issues with residents. DON or designee will audit random aides weekly for knowledge of how to use KARDEX and find careplanned interventions. Audit will continue for one quarter or until 100% compliance is reached.** **What measures will be put into**	

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	move from sitting to standing, move from lying to sitting on the side of the bed, chair to bed and bed to chair transfers and toilet transfers. The resident was frequently incontinent of bowel and bladder. A 3/13/24, quarterly, MDS assessment indicated Resident 22 was moderately cognitively impaired. The resident required substantial/maximal assistance with toileting hygiene, showering/bathing, and upper and lower body dressing. The resident was dependent on staff for putting on/taking off footwear and personal hygiene. The resident required substantial/maximal assistance to roll left and right, move from lying to sitting on the side of bed, move from sitting to standing, chair to bed and bed to chair transfers, and transfers to the toilet. The resident was frequently incontinent of bowel and bladder. She had one fall with no injury and one fall with major injury since the prior assessment. A current fall care plan, initiated on 12/6/23 and revised on 12/11/23, indicated the resident was at risk for falls related to muscle weakness, history of falls and impaired mobility. Interventions included anticipate and meet the resident's needs (12/6/23), be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed (12/6/23), and fall mat to bedside when in bed per family request (3/28/24). A nurses note, dated 12/20/23 at 1:57 p.m., indicated the resident had been increasingly lethargic throughout the shift and was unable to concentrate once awakened. Hospice discontinued a hydrocodone (opiate pain medication) order and started tramadol 50 mg (opiate pain medication) twice a day.		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** **All staff was provided education at the April All Staff inservice on what interventions were appropriate for falls, with emphasis on what intentional rounding and increased rounding means. All staff were also shown how to use the KARDEX on PointClick Care to look up interventions for careplanned issues with residents. The C.N.A orientation checklist was also updated to ensure that all new hired aides are aware of where to find this information. DON or designee will audit random aides weekly for knowledge of how to use KARDEX and find careplanned interventions. Audit will continue for one quarter or until 100% compliance is reached. The DON or designee will also audit the new hire orientation checklists for one quarter or until 100% compliance is reached. Results of this audit** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place?** **All staff was provided**	

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	A nurses note, dated 1/17/24 at 6:35 p.m., indicated the resident's roommate called staff to the room. According to the roommate the resident slid out of bed from a seated position on the side of the bed. The resident was found on the floor with her back against the bedside. She indicated she was going to the bathroom. X-rays for the left shoulder and both hips were ordered. A nurses note, dated 1/18/24 at 2:00 a.m., indicated the X-ray results were received with no obvious or acutely displaced fractures. An Interdisciplinary Team (IDT) note, dated 1/19/24 at 1:48 p.m., indicated the 1/17/24 fall was reviewed. The resident had been sitting on the side of her bed when she attempted to stand and slid to the floor. She was found sitting upright next to the bed. The resident had also recently been diagnosed with COVID-19 and had been slightly weaker than baseline. An intervention was initiated to have the staff complete more frequent rounding on the resident. A current care plan, initiated 1/21/24, indicated the resident had a fall on 1/17/24. The intervention was more frequent rounding (1/21/24). A nurses note, dated 2/15/24 at 6:20 a.m., indicated a housekeeper witnessed Resident 22 fall while trying to get up on her own. The resident lost her balance and fell backward. The nurse found Resident 22 on the floor, beside the bed, with her head under the bed. The resident's bed was found soaked, and she was in a puddle of urine. The resident indicated she was getting up to go to the bathroom. Staff were educated on needing to take the resident to the toilet frequently. The resident was known to hold urine until taken to the toilet and could not always let		**education at the April All Staff inservice on what interventions were appropriate for falls, with emphasis on what intentional rounding and increased rounding means. All staff were also shown how to use the KARDEX on PointClick Care to look up interventions for careplanned issues with residents. The C.N.A orientation checklist was also updated to ensure that all new hired aides are aware of where to find this information. The DON or designee will audit the new hire orientation checklists for one quarter or until 100% compliance is reached. Results of this audit will be discussed in QAPI and the QAPI committee will review after 100% compliance is reached for need to continue audit.**	

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	needs be known. A nurses note, dated 2/15/24 at 3:41 p.m., indicated X-ray results had been received and concluded there was an acute appearing acromion (shoulder) fracture to the left side. An IDT note, dated 2/22/24 at 9:04 a.m., indicated the fall on 2/15/24 was reviewed. Staff present at the time of fall reported Resident 22 was heavily incontinent of urine at the time, and the resident had reported she was attempting to go to the bathroom. The IDT spoke with the staff who worked prior to the fall. The staff indicated they were under the impression that the resident used her call light, and would ask for assistance with bathroom needs, as this was her normal previously when she resided in another part of the building. Staff indicated they did not know the resident would attempt to toilet herself. A facility investigation of the 2/15/24 fall, provided by the Administrator on 4/18/24 at 2:42 p.m., indicated staff had assisted the resident's roommate at 5:00 a.m. The resident was asleep at the time. Staff indicated they had not returned to the room to check on Resident 22, as staff was waiting for the resident to turn on her call light. The staff were educated on how some residents do not use call lights to get assistance for their needs and intentional rounding should be performed every two hours. A CNA assignment sheet, provided by LPN 10 on 4/19/24 at 10:19 a.m., indicated the resident required assistance of 1 to 2 persons and "frequent" rounding. During an interview, on 4/19/24 at 10:12 a.m., CNA 9 indicated she was uncertain what frequent			

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	rounding meant. She checked on the resident every two hours to see if she needed to go to the bathroom. During an interview, on 4/19/24 at 10:36 a.m., CNA 7 indicated she did not know what frequent rounding meant on the CNA assignment sheet. During an interview, on 4/19/24 at 11:06 a.m., CNA 11 indicated she was not sure what frequent rounding meant. She looked at the CNA assignment sheet and indicated it meant to check on the resident frequently. She was not sure if there was an exact time frame, but she tried to look at the resident when she walked up and down the hall. First thing in the morning and if the resident seemed agitated, she would offer to take her to the bathroom. During an interview, on 4/19/24 at 2:23 p.m., the DON indicated the definition of frequent rounding meant more frequently than every two hours. When the staff walked down the hall, they should be looking specifically at the residents who fall. A current policy, revised on 7/22/21, provided by the DON on 4/19/24 at 3:11 p.m., titled "Fall policy and procedure," indicated " ...All falls, regardless of injury, will be reviewed the following morning, during normal business hours by the Interdisciplinary Team (IDT) to determine if the fall process was followed and an appropriate intervention was put in place ...." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to provide incontinence care in a hygienic manner for 1 of 3 residents reviewed for urinary tract infections (UTIs) (Resident 115). Finding includes:	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **One resident was affected by this deficient practice. Resident**	05/20/2024

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	During a perineal care (washing of the genitals and rectal areas) observation, on 4/18/24 at 10:57 a.m., Resident 115 was laying on her back in the bed. CNA 9 washed under the resident's abdomen and thigh creases. Using the same washcloth, the CNA next washed Resident 115's labia from back to front. The CNA repeated the same steps, in the same order, with another washcloth to rinse the same areas. Resident 115's record was reviewed on 4/21/24 at 8:32 a.m. Diagnoses included type 2 diabetes mellitus and need for assistance for personal care. The current physician orders included a urinalysis with culture and sensitivity (urine testing for infection) to be collected via in and out catheter for dysuria and altered mental status (4/18/24) and nitrofurantoin (antibiotic) 100 mg two times a day for five days for UTI (4/21/24). An admission, 4/11/24, Minimum Data Set (MDS) assessment indicated the resident was dependent on the staff for toileting hygiene, showering/bathing, and personal hygiene. She required substantial/maximal assistance to roll left and right, move from sitting to lying position, and lying to sitting position. The resident was frequently incontinent of bowel and bladder. A care plan, initiated 3/22/24, indicated the resident may be incontinent of urine. Interventions included check and change as needed (3/22/24) and provide perineal care after incontinence episode (3/22/24). A nurses note, dated 4/17/24 at 11:33 a.m., indicated a urinary specimen for a U/A C&S was collected.		**began an antibiotic and has no ill effects related to treatment. All C.N.A's were re-educated in the April All Staff inservice on proper incontinence care. Compentencies were completed will all C.N.A's to ensure that proper techniques are used.** **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 had the potential to be affected by this deficient practice. All C.N.A's were re-educated in the April All Staff inservice on proper incontinence care. Compentencies were completed will all C.N.A's to ensure that proper techniques are used. Unit Managers will audit one opportunity per day (M-F) for proper techniques used for incontinence care for one quarter or until 100% compliance is reached.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **All residents had the potential to be affected by this deficient practice. All C.N.A's were re-educated in the April All**	

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	During an interview, on 4/18/24 at 11:12 a.m., CNA 9 indicated she had washed the resident from back to front, and should have washed the resident from front to back, when performing incontinence care. She thought because she was standing towards the resident's head she got mixed up. During an interview, on 4/18/24 at 11:17 a.m., RN 8 indicated she had noticed during the incontinence care the resident had been wiped from back to front, and should have been wiped from front to back. During an interview, on 4/19/24 at 2:36 p.m., the DON indicated CNA 9 had told her she had performed perineal care incorrectly. The CNA should have washed, rinsed, and dried the resident's perineal area from front to back. A nurses note, dated 4/20/24 at 2:50 p.m., indicated the facility had received the urine culture results and was awaiting a return call from the physician. A nurses note, dated 4/21/24 at 1:55 p.m., indicated the physician had ordered an antibiotic for the urinary culture results. A care plan, initiated 4/21/24, indicated the resident was on antibiotic therapy for UTI. A current facility policy, revised on 4/1/19, provided by the DON on 4/19/24 at 3:14 p.m., titled "Peri care Policy," indicated " ... 8. For female residents, separate the labia., a. Wash with soapy washcloth, from front to back, using the clean area of the washcloth with each stroke. b. Rinse area, moving from front to back, using the clean area of the washcloth for each stroke. c. Dry area moving		**Staff inservice on proper incontinence care. Compentencies were completed will all C.N.A's to ensure that proper techniques are used. Unit Managers will audit one opportunity per day (M-F) for proper techniques used for incontinence care for one quarter or until 100% compliance is reached. Annual competencies will be completed with C.N.A's. Re-education will be provided as needed.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place? All residents had the potential to be affected by this deficient practice. All C.N.A's were re-educated in the April All Staff inservice on proper incontinence care. Compentencies were completed will all C.N.A's to ensure that proper techniques are used. Unit Managers will audit one opportunity per day (M-F) for proper techniques used for incontinence care for one quarter or until 100% compliance is reached. Results from audit will be taken to QAPI and discussed. QAPI committee will discuss results of audit and need to continue**	

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	from front to back, using a blotting motion with the towel ...." 3.1-41(a)(2)		**after 100% compliance is reached. Annual competencies will be completed with C.N.A's. Re-education will be provided as needed.**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to properly administer medications as ordered by the physician. There were 26 opportunities with 2 errors, resulting in a 7.69% medication administration error rate. These errors involved 2 of 6 residents observed for medication administration. (Residents 31 and 50) Findings include: 1. During an observation of medication administration for Resident 31, on 4/18/24 at 11:24 a.m., QMA 5 prepared the following medication to administer: Insulin Aspart (to treat diabetes), 2 units. The insulin vial was dated 3/20/24 for the opened date. QMA 5 administered the 2 units of insulin for Resident 31 in the lower left quadrant of her abdomen. 2. During an observation of medication administration for Resident 50, on 4/18/24 at 11:26 a.m., QMA 5 prepared the following medication to administer:	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **One resident was found to be affected by this deficient practice. All med carts were audited for expired medications.** **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. All med carts were audited for expired medications. Any medications that were within one week of expiring will have a yellow dot added to it to ensure nurses are prompted to order new medication. Nurses will check insulins at the beginning of**	05/20/2024

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	NovoLOG (Insulin Aspart), 1 unit, the insulin vial was dated 3/18/24 for the opened date. QMA 5 administered the 1 unit of insulin for Resident 50 in her left forearm. During an interview, at the time of observation, QMA 5 indicated the dates on the insulin vials were 3/18/24 and 3/20/24, and most insulin expired 28 days after opening. Resident 31's clinical record was reviewed on 4/18/24 at 12:05 p.m., current physician's orders for the resident included: Insulin Aspart Injection Solution (Insulin Aspart), Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 unit; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously before meals and at bedtime for Diabetes. Call MD for Blood Sugar less than 60 or above 400. Resident 50's clinical record was reviewed on 4/18/24 at 12:05 p.m., current physician's orders for the resident included: NovoLOG Injection Solution 100 UNIT/ML (milliliter) (Insulin Aspart), Inject as per sliding scale: if 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 - 450 = 6 units, subcutaneously before meals for diabetes. During an interview, on 4/18/24 at 3:36 p.m., the DON indicated the "Product Expiration Dates guidelines" were kept on the medication carts and QMA 5 should not have given NovoLOG or Aspart insulin with an opened date greater than 28 days from day of administration. A current facility document, revised May 2023, titled, "Product Expiration Dates," provided by the Corporate Nurse Consultant, on 4/18/24 at 3:19		**each shift to ensure all medications are not expired.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **All med carts were audited for expired medications. Any medications that were within one week of expiring will have a yellow dot added to it to ensure nurses are prompted to order new medication. Nurses will check insulins at the beginning of each shift to ensure all medications are not expired. Unit Managers will audit med carts weekly for expired medications for one quarter or until 100% compliance is reached.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place?** **All med carts were audited for expired medications. Any medications that were within one week of expiring will have a yellow dot added to it to ensure nurses are prompted to order new medication. Nurses will check insulins at the beginning of each shift to**	

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	p.m., indicated the following: "...Insulin vials at room temperature expiration date is 28 days...." A current facility policy, approved 5/20/22, titled, "Insulin Preparation and Administration," provided by the Corporate Nurse Consultant, on 4/18/24 at 3:19 p.m., indicated the following: "...Procedure...7) Insulin Vial Procedure...b. Check insulin vial to ensure correct type and check expiration date...." 3.1-48(c)(1)		**ensure all medications are not expired. Unit Managers will audit med carts weekly for expired medications for one quarter or until 100% compliance is reached. All results from the audit will be discussed in QAPI. The QAPI committee will determine if the need for the audit is needed after compliance is reached.**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 15, 16, 17, 18, 19, and 22, 2024. Facility number: 000372 Residential Census: 17 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review May 1, 2024.	R 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 residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and			

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	procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.			
	Based upon record review and interview, the facility failed to perform pharmacy medication reviews, at least once every sixty (60) days, for 3 of 5 clinical record reviews and 1 of 1 closed record reviews. (Residents 2, 13, 15, and 101) 1. Resident 13's clinical record was reviewed on 4/22/24 at 9:38 a.m. Current diagnoses included unspecified dementia, chronic obstructive pulmonary disease, schizoaffective disorder, anxiety, and agoraphobia. Pharmacy reviews were documented for April 2023, June 2023, and August 2023. The clinical record lacked pharmacy reviews for the months of October 2023, December 2023, and February 2024. 2. Resident CL 101's clinical record was reviewed 4/22/24 at 11:51 a.m. Current diagnoses included hyperlipidemia, unspecified intellectual disabilities, and muscle weakness. Pharmacy reviews were documented for April 2023, June 2023, August 2023, and October 2023. The clinical record lacked a pharmacy review for the month of December 2023. 3. Resident 2's clinical record was reviewed on 4/22/24 at 10:04 a.m. Current diagnoses included, but were not	R 0298	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **Four resident's were found to have been affected by this deficient practice. All pharmacy recommendations were reviewed and sent to the MD for signature. AL Manager has followed up with MD if recommendations were not addressed.** **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 resident's had the potential to be affected by this deficient practice. AL Manager was not tracking recommendations to ensure they were completed. All resident charts were reviewed to ensure all recommendations were completed. An audit has been developed to ensure that all**	05/20/2024

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	limited to, chronic obstructive pulmonary disease (COPD), combined systolic & diastolic heat failure, anxiety disorder, Type II diabetes mellitus, chronic kidney disease, polyneuropathy, hypertrophic osteoarthropathy, and muscle weakness. Pharmacy reviews were documented for the months of April 2023, June 2023, August 2023, and February 2024. The clinical record lacked pharmacy reviews for the months of October 2023 and December 2023. 4. Resident 15's clinical record was reviewed on 4/19/24 at 1:30 p.m. Current diagnoses included chronic kidney disease, Stage 3B malignant neoplasm of unspecified site of right female breast, and mild cognitive impairment of uncertain or unknown etiology. Pharmacy reviews were documented for April 2023, June 2023, and October 2023. The clinical record lacked pharmacy reviews for the months of August 2023, December 2023, and February 2023. During an interview, on 4/22/24 at 2:16 p.m., the DON indicated the facility had no other pharmacy review documents. During an interview, on 4/22/24 at 2:40 p.m., the Administrator indicated the Assisted Living facility did not have a policy related to pharmacy reviews.		**recommendations are followed up on and completed.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **AL Manager now tracks all pharmacy recommendations to ensure they are completed.** **The DON or designee will audit all pharmacy recommendations to ensure all pharmacy recommendations are completed. Audit will continue until 100% compliance has been reached for one quarter. Education was provided to the AL Manager that all pharmacy recommendations must be sent to MD and then provide follow up if they are not completed and returned.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place?** **AL Manager now tracks all pharmacy recommendations to ensure they are completed.** **The DON or designee will audit all pharmacy recommendations to ensure all pharmacy recommendations**	

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			are completed. Results from this audit will be addressed in QAPI. Once 100% compliance has been reached for 1 quarter, QAPI committee will review for need to continue audit.	