STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155522	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elwood Health and Living	2300 Parkview LN Elwood, IN 46036

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45122 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. 48384 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45122 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: 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, 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45122 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: 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. 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 from front to back, using a blotting motion with the towel 3.1-41(a)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146 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 [DATE] 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 [DATE] 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 [DATE] at 11:26 a.m., QMA 5 prepared the following medication to administer: NovoLOG (Insulin Aspart), 1 unit, the insulin vial was dated [DATE] 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 [DATE] and [DATE], and most insulin expired 28 days after opening. Resident 31's clinical record was reviewed on [DATE] 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 [DATE] 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 [DATE] 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 [DATE], titled, Product Expiration Dates, provided by the Corporate Nurse Consultant, on [DATE] at 3:19 p.m., indicated the following: .Insulin vials at room temperature expiration date is 28 days (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, approved [DATE], titled, Insulin Preparation and Administration, provided by the Corporate Nurse Consultant, on [DATE] 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 3XXX,d+[DATE](c)(1)