

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Ashton Creek Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4111 Park Place Drive Fort Wayne, IN 46845	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794</b></p> <p>Based on observation, interview and record review, the facility failed to ensure assistance was provided with managing denture care and grooming of facial hair for 1 of 6 residents reviewed (Resident 40).</p> <p>Findings include:</p> <p>On 7/16/24 at 9:48 AM Resident 40 was observed to have 5 coarse dark hairs on their chin. The hairs were approximately one-half inch long. Resident 40 was observed to be missing their upper front teeth.</p> <p>Resident 40's record was reviewed on 7/17/24 at 9:50 AM. Diagnoses included Alzheimer's, Disease, anxiety, depression and a cerebral infarction (stroke).</p> <p>Resident 40's Annual MDS dated [DATE] indicated their BIMS score was 12 (moderate cognitive loss according to CMS (CMS.gov, 2024). The MDS indicated Resident 40 required supervision or touching assistance with oral care and personal hygiene. The MDS indicated Resident 40 did not have issues with their dental health.</p> <p>Resident 40's Care Plan dated 10/9/23 indicated the resident required assistance with activities of daily living (ADLs) due to depression, a history of falls, stroke and weakness. The target goal was for Resident 40's ADL ability to improve by 7/16/24. Interventions included therapy as needed, supervision with eating and extensive assistance with toileting, bed mobility and transfers.</p> <p>The Care Plan did not include assistance with oral care or the resident's partial denture.</p> <p>The Care Plan did not include the resident's preference for removal of facial hair.</p> <p>A dental visit note dated 2/28/24 indicated Resident 40 had requested tooth replacement for their upper front teeth after recently having the teeth extracted. The note indicated Resident 40 had a set of teeth with lots of bridge work. The note indicated Resident 40 should have their teeth brushed twice daily. The note indicated Resident 40 should have their teeth flossed once daily.</p> <p>A dental hygienist visit note dated 4/24/24 indicated Resident 40 had heavy plaque on their teeth, generalized severe gingivitis and periodontitis (inflammation of the gums). The note indicated Resident 40 was to have their teeth brushed 2 to 3 times daily with a soft bristle brush.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A dental assistant visit note dated 5/1/24 indicated Resident 40 received a partial denture that replaced the resident's upper front teeth. The note indicated Resident 40 should be assisted with placing the denture in their mouth in the morning, removing the denture at bedtime, cleaning the denture and placing the denture in a denture cup.</p> <p>In an interview on 7/17/24 at 1:05 PM, Resident 40 indicated they were not wearing their partial denture due to forgetting the denture at home. Resident 40 laughed and indicated their mom always asks them the same question.</p> <p>In a phone interview on 7/17/24 at 1:41 PM, Resident 40's family member indicated the resident's denture was very difficult to apply. The family member indicated the denture interfered with Resident 40's speech. The family member indicated they had made the facility aware of the denture not fitting properly. The family member indicated they had told an unidentified CNA about Resident 40's denture not fitting properly. The family member indicated Resident 40 did not like the hairs on their chin. The family member indicated they had encouraged Resident 40 to ask the beautician to include facial hair removal, but the resident was very forgetful. The family member indicated Resident 40 displayed confusion at times. The family member indicated they had forgotten to ask the beautician to shave or pluck the hairs from the resident's chin. The family member suggested to the facility they could bring a razor from home to shave the resident's chin, but had been assured the facial hair would be removed by the beautician. The family member indicated Resident 40 visited the facility beauty shop because they had always wanted to look their best.</p> <p>In an interview with Certified Nurse Aide (CNA) 20 and CNA 21 on 7/22/24 at 9:27 AM, CNA 20 indicated Resident 40 did not usually wear their denture because the denture did not fit correctly and Resident 40 did not like the way their tongue touched the denture when they talked. CNA 21 indicated Resident 40 had declined wearing their denture ever since they had received the denture. CNA 21 indicated Resident 40's denture care was not on the resident's Kardex (a summary of the resident's care plan).</p> <p>In an interview on 7/22/24 at 9:40 AM, the Director of Nursing (DON) indicated they did not know why Resident 40 had been declining the use of their partial denture. The DON indicated they did not know if the dentist had been made aware of Resident 40 not wearing their partial denture.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Administrator, the DON and the Regional Nurse Consultant on 7/22/24 at 10:23 AM, the Regional Nurse Consultant provided Resident 40's undated Kardex. The Regional Nurse Consultant indicated Resident 40 had refused to wear their partial denture. The Regional Nurse Consultant indicated Resident 40 had never requested the removal of their facial hair. The Regional Nurse Consultant indicated Resident 40's Kardex and Care Plan included the resident's refusal to wear their denture. The Regional Nurse Consultant indicated Resident 40's Kardex and Care Plan included the resident was to request facial hair removal from the staff. The Regional Nurse Consultant indicated the Kardex and Care Plan had been updated to reflect the denture refusal and facial hair removal either on Thursday 7/18/24 or Friday 7/19/24. The Regional Nurse Consultant indicated they were unaware of the partial denture not being included on Resident 40's Care Plan. The Administrator indicated they were unaware there was no documentation of Resident 40's refusal of to wear their denture. The DON indicated they were not aware of Resident 40's denture not fitting correctly. The DON indicated they were not aware of Resident 40's Care Plan not addressing oral care, denture care or the resident's preference for facial hair removal. The Regional Nurse Consultant indicated Resident 40's BIMS score was 12 and the resident could request staff assistance with facial hair removal if they chose. The Regional Nurse Consultant agreed facial hair removal should be offered by the staff and the resident should not be required to ask.</p> <p>A current facility policy titled Activities of Daily Living dated 11/28/23 provided by the DON on 7/22/24 at 9:50 AM indicated the facility would provide care and services for bathing, dressing, grooming and oral care. The policy did not include denture care. The policy did not include facial hair grooming.</p> <p>A current facility policy titled Oral Care dated 11/29/23 provided by the DON on 7/22/24 at 9:50 AM indicated the facility would provide oral care to prevent and control plaque associated oral diseases. The oral care policy did not include denture care.</p> <p>According to the Centers for Medicare and Medicaid Services, (CMS) a BIMS score of 0-7 indicates severe cognitive loss, a score of 8-12 indicates a moderate cognitive loss and a score of 13-15 indicates no cognitive loss (CMS.gov, 2024).</p> <p>3.1-38(a)(3)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756</b></p> <p>Based on observation, interview, and record review the facility failed to ensure meal intakes and weights were monitored for 2 of 3 residents reviewed (Resident B and Resident 305).</p> <p>Findings include:</p> <p>1. During an interview on 7/16/24 at 11:13 AM, Resident B's family member indicated he was concerned about Resident B's nutritional status and meal intakes. He indicated Resident B was not offered meal trays at the dinner meal on 6/15/24 and the breakfast and lunch meals on 6/29/24. He indicated Resident B had poor meal intakes and was not provided assistance at many additional meals including breakfast on 6/22/24, the dinner meal on 6/24/24, the dinner meal on 6/26/24, the dinner meal on 6/27/24, and the dinner meal on 6/28/24. He was concerned additional meals may not have been offered and his father may not have been offered the assistance he needed to eat.</p> <p>Resident B's record was reviewed on 7/16/24 at 1:48 PM. Diagnoses included Alzheimer's disease with late onset, need for assistance with personal care, and cognitive communication deficit.</p> <p>Resident B's current admission Minimum Data Set (MDS) dated [DATE] indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired). The MDS indicated the resident required supervision or touching assistance with eating tasks. The MDS indicated Resident B required a therapeutic diet and was not receiving therapy or restorative programs for eating assistance.</p> <p>Meal intake records provided by the Director of Nursing (DON) on 7/18/24 at 10:46 AM indicated meal intake amounts were not recorded for the following meals:</p> <p>6/13/24 dinner, 6/14/24 dinner, 6/15/24 dinner, 6/17/24 breakfast, 6/18/24, breakfast, lunch and dinner, 6/22/24, breakfast and lunch, 6/25/24, dinner, 6/26/24, breakfast, lunch, and dinner, 6/27/24, dinner, 6/28/24, dinner,  (continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/30/24 dinner,</p> <p>7/1/24, dinner,</p> <p>7/3/24 breakfast and lunch,</p> <p>7/4/24 dinner,</p> <p>7/5/24 dinner,</p> <p>7/6/24 lunch and dinner,</p> <p>7/16/24 lunch and dinner.</p> <p>An admission assessment dated [DATE] indicated Resident B weighed 148.6 lbs (pounds) and did not have any edema. Additional weights reviewed included:</p> <p>6/14/24 147.6 lbs</p> <p>6/18/24 145.6 lbs</p> <p>7/1/24 138.6 lbs</p> <p>7/8/24 136.6 lbs</p> <p>7/19/24 134.6 lbs</p> <p>On 06/12/2024, the resident weighed 148.6 lbs. On 07/01/2024, the resident weighed 138.6 pounds which is a -6.73 % Loss.</p> <p>Progress notes dated 7/12/24 indicated Resident B's son had refused to have supplements offered to Resident B due to concerns about preservatives used in the supplements offered.</p> <p>A review of all other progress notes from admission on 6/12/24 to 7/17/24 did not indicate any refusals of offered food items or any refusal of weights. No records of offering any alternative supplements or additional food offerings to offset weight loss were available for review.</p> <p>Resident B's current care plan titled I receive supplements, dated 6/13/24, with a goal date of 9/27/24 indicated Resident B should receive supplements as ordered. A review of current orders did not indicate any supplements were currently ordered.</p> <p>Resident B's current care plan dated 6/13/24, titled I have specific choices, with a goal date of 9/27/24 indicated Resident B chose to get up in the morning between 8 and 9 AM. The care plan did not indicate a preference for whole food supplements.</p> <p>Resident B's current care plan dated 6/13/24, titled I am at risk for malnutrition, with a goal date of 9/27/24, indicated Resident B should have his meal intakes and weights reviewed, and should receive his reduced carbohydrate diet as ordered.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/19/24 at 11:25 AM, the Regional Dietician indicated the resident should have had weights monitored weekly as soon as a weight loss was identified, and staff would benefit from review of meal documentation procedures.</p> <p>In an interview on 7/19/24 at 12:59 PM, the Regional Dietician indicated she had updated Resident B's care plan to reflect weight fluctuation due to edema. In the same interview, the Unit Manager indicated upon admission, Resident B did not receive breakfast because he preferred to get up after 10 AM.</p> <p>A current policy titled Nutrition at Risk (NAR) Policy, dated 10/21, provided by the Assistant Director of Nursing on 7/18/24 at 12:50 PM indicated the facility should aggressively review and address those residents exhibiting significant weight change, skin breakdown or potential nutritional decline through NAR. The policy indicated residents with weight changes of 5% or more unplanned weight loss in 30 days should be monitored weekly by the clinical team with dietary and clinical interventions reviewed and documented.</p> <p>46818</p> <p>2. Resident 305's record was reviewed on 7/16/24 at 1:24 PM. Diagnoses included cerebral infarction (stroke), aphasia (difficulty speaking), and dysphagia (difficulty swallowing).</p> <p>A review of Resident 305's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 4 (severe cognitive impairment). The MDS indicated Resident 305 received a score of 2 during eating, which indicates a need for substantial to maximum assistance with eating. Section K (swallowing/nutritional status) indicated food escaping from the mouth when chewing, holding onto residual food in mouth after meals, and coughing or choking during meals or when swallowing medications.</p> <p>A review of Resident 305's current care plan titled I am malnourished, with a goal date of 9/26/24 indicated Resident 305 should have their weights reviewed, receive their supplements, and receive vitamin and/or mineral supplement, as ordered.</p> <p>A review of Resident 305's current care plan titled I require an altered consistency diet due to difficulty swallowing, with a goal date of 9/26/24 indicated Resident 305 will receive their mechanical soft diet as ordered.</p> <p>A review of Resident 305's current care plan titled I am now receiving comfort care related to diagnosis of stroke, with a problem of weight loss is expected with a goal date of 9/26/24 indicated Resident 305 should have their dietary preferences honored to the extent possible.</p> <p>A review of Resident 305's current care plan titled I need assistance with my ADL's (activities of daily living) related to stroke, fracture of right humerus, hypertension, diabetes type 2, and muscle weakness, with a goal date of 9/26/24 indicated Resident 305 requires extensive assistance from 1 staff with eating.</p> <p>A review of resident 305's current care plan titled I receive supplements, with a goal date of 9/26/24 indicated Resident 305 would receive supplements as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of physician orders dated 7/22/24 indicated Resident 305 would receive a glucose control boost supplement twice daily for inadequate oral intake.</p> <p>A review of Resident 305's weight indicated a 20.32% weight loss, from 186 pounds on 6/3/24 at 10:55 AM to 148.2 pounds on 6/10/24 at 2:13 PM. Subsequent weights for Resident 305 were 146 pounds on 6/17/24 1:15 PM, 148.6 pounds on 6/24/24 at 11:44 AM, and 141.2 pounds on 7/11/24 9:32 AM.</p> <p>During an interview on 7/19/24 at 12:59 PM, the Regional Dietician indicated when a resident was a participant of the NAR program they should have weekly weights.</p> <p>During an interview on 7/19/24 at 12:59 PM, Employee 22 indicated Resident 305 presented upon admission in poor condition. Resident 305 was immediately sent to Lutheran Hospital where an initial weight of 200.2 pounds was recorded for weight on 5/2/24 at 3:42 PM. Upon admission to the facility on [DATE] at 7:38 PM Resident 305 weighed 200 pounds.</p> <p>During an interview on 7/22/24 at 10:24 AM, the DON, Administrator and Regional Nurse Consultant indicated weights were monitored through the NAR process. They indicated they do not normally have consistent staff obtaining weights, so a CNA obtaining a weight would not necessarily be aware of weight loss at the time the weight was obtained. They indicated the CNA staff would be notified of any reweights needed after the NAR process was completed. They were unable to identify why reweights were not obtained when a weight variance initially occurred.</p> <p>A current policy titled Nutrition at Risk (NAR) Policy, dated 10/21, provided by the Assistant Director of Nursing on 7/18/24 at 12:50 PM indicated the facility should aggressively review and address those residents exhibiting significant weight change, skin breakdown or potential nutritional decline through NAR. The policy indicated residents with weight changes of 5% or more unplanned weight loss in 30 days.</p> <p>This citation is related to complaint IN00438109.</p> <p>483.25(g)(1)-(3)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46756</p> <p>Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed when necessary, in the meal preparation and service process. 110 of 110 residents residing in the facility consumed food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During an observation on 7/16/24 at 9:15 AM the Dietary Manager (DM) picked up a garbage can lid from the floor and placed it back on top of the garbage can. No hand hygiene was performed, and she continued the kitchen tour opening the ice machine door and the walk-in cooler door.</p> <p>During an observation on 7/16/24 at 10:31 AM [NAME] 25 was using a blender to prepare pureed chicken for the lunch meal. During the process, the lid became loose, splattering a small amount of pureed chicken onto [NAME] 25's hands. [NAME] 25 wiped her hands on her uniform and continued the puree process, then handled the clean container the pureed chicken was poured into and the clean utensils without performing hand hygiene.</p> <p>During an observation on 7/17/24 at 11:07 am in the 400-hall dining room, [NAME] 27 was placing plates of food onto food trays, covering them with a lid, and loading them onto a cart for distribution. During the process, [NAME] 27 slapped her hands down onto her uniform pants, placed her hands on her hips, touched her uniform 5 times and continued touching plates of food. [NAME] 27 did not perform any hand hygiene throughout the loading of the meal tray cart and meal service to several residents seated in the dining area.</p> <p>During an observation on 7/17/24 at 11:17 AM, [NAME] 26 was observed touching his face and continuing with meal tray assembly without performing hand hygiene. [NAME] 26 then spilled a container of packaged butter pats on the floor, picked up the pats, and continued with meal tray assembly without performing hand hygiene. [NAME] 26 did not perform any hand hygiene throughout the loading of the meal tray cart and meal service to several residents seated in the dining area.</p> <p>In an interview on 7/17/24 at 11:22 AM, the Assistant Dietary Manager indicated staff should perform hand hygiene prior to taking their workstation and any time hands are contaminated throughout the meal service process.</p> <p>A current policy titled Handwashing dated 10/17 provided by the Dietary Manager on 7/17/24 at 11:38 AM indicated hand hygiene should occur during food preparation as often as necessary to remove contamination and to prevent cross contamination when changing tasks.</p> <p>3-1-21(i)(3)</p>		