STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 14, 15, 16, 17, 18, 22, 23, and 24, 2013 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 Survey team: Dinah Jones, RN-TC Patti Allen, BSW Leia Alley, RN Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicare: 2 Medicaid: 41 Other: 3 Total: 46 These deficiencies reflect state findings in accordance with 410 IAC 16.2. Quality Review completed on February 01, 2013; by Kimberly Perigo, RN.	F0000		

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 determined that other safegaurds 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.

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, interview, and record review the facility failed to notify a medical doctor of significant change in health condition for 1 of 10 residents reviewed for unnecessary	F0157	For Resident #10, we have implemented a Diabetic Monitoring Flow Sheet on which we will document blood glucose results and physician notification. All diabetic residents in the facility	02/23/2013

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	medications in a sample of 10 residents who met the criteria for unnecessary medication use. Resident #10. The Clinical Records for Resident #10 were reviewed on 1/22/13 at 1:00 p.m. Diagnoses included but were not limited to, diabetes mellitus (a condition affecting blood sugar levels). Resident #10's clinical record indicated a physicians order started 3/28/11 to "Check blood sugar two times daily, call MD [medical doctor] if below 70 or above 400." The record indicated a high blood sugar level of 416 on 11/2/12. The record also indicated that the blood sugar reading to be done daily at 4:00 p.m., was not done on 11/29/12, 12/13/12, nor 12/24/12. A request for further information in regards to the blood sugar monitoring was requested of the Assistant Director of Nursing (ADON) on 1/22/13 at 2:30 p.m. During an interview with the ADON on 1/23/13 at 9:00 a.m., she indicated no		are identified as having potential to be affected. Diabetic Monitoring Flow Sheets will be initiated on every resident with orders to routinely check blood glucose levels. The DON or ADON will check rewrites monthly to insure the Diabetic Monitoring Flow Sheets are in place for each diabetic resident. The medical records clerk is responsible to place these forms. The Diabetic Monitoring Flow Sheets will be audited weekly X 4 weeks by the Director of Nursing or designee to make sure that physicians are notified as ordered in the event of abnormal blood sugar results. If compliance is at 100% for three weeks in a row, audits will reduce to twice monthly X 3 months. If compliance is at 100% X 2 months in a row, audits will reduce to monthly, and will remain monthly on an ongoing basis. Results of these audits will be taken to the QA Committee to be reviewed at least quarterly. A meeting of all licensed nurses has been scheduled for 2/20/2013 to review the policy. Director of Nursing is responsible for compliance. Completion Date 2/23/2013ADDENDUM The licensed nurse who failed to follow the order to notify the physician of Resident # 10's blood glucose level is no longer employed at the facility. The Diabetic Flow Sheet is implemented to facilitate documentation of physician	

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	further information was available for the blood sugar monitoring. During an interview with the facility Minimal Data Set (MDS) Coordinator on 1/24/12 at 2:00 p.m., a facility policy for Diabetic Monitoring was requested. A facility policy dated 2005 and titled "Blood Sugar Monitoring" indicated "If blood glucose level is above or below normal range, document the time the physician was notified" and to "Check physicians order for blood sugar testing frequency." 3.1-5(a)(3)		notifications and also improve the ability to audit the records in order to assure compliance.	

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F0223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review, the facility failed to keep residents free from abuse for 2 of 6 residents reviewed for abuse in a sample of 6 residents who met the criteria for abuse. Resident #33 and #54. Findings Include: Resident #33's clinical records were reviewed on 1/18/13 at 1:45 p.m. Diagnoses for Resident #33 included but were not limited to, liver failure, and anemia. A Quarterly MDS (Minimum Data Set) assessment indicated Resident #33 had a BIMS (Brief Interview for Mental Status) score of 15 out of a possible 15 points, indicating Resident #33 was cognitively intact. During an interview with Resident #33 on 1/18/13 at 1:30 p.m, Resident #33 indicated he was, "pulled and pushed	F0223	As always, this facility takes allegations of abuse very seriously and strives to make each one of our residents safe. We continue to report those allegations as outlined by law. In this population, intervention with all allegations are at times challenging due to the accuracy of the informer. The facility assures that all allegations are investigated and appropriate action has been done, including separation of the resident from the alleged threat, and prompt suspensions and reporting. As with Resident #33 the C.N.A. was suspended as soon as the resident reported the incident. She was not allowed to return to work. She resigned instead of accepting termination. This was also reported to ISDH. Staff intervened immediately in the case of Resident 54. Resident 53 and Resident 54 were promptly separated, and Resident #53 was sent to an acute care hospital and has since been accepted by another facility and will not return here. All residents in the facility	02/23/2013

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	too hard" by a CNA (Certified Nurses Assistant). Resident # 33 indicated that when the CNA rolled him over to help him clean up, she pushed him so hard that he banged his knee on a nearby window sill. Resident #33 showed a bruise on his leg and indicated it was very sore. Resident #33 indicated this made them feel very bad and indicated, "he didn't want to be a burden, but wouldn't ask for help if he didn't need help." He indicated that he was, "a big guy" and indicated, "I don't want to get nobody in trouble, but it's not ok to treat people like that [indicating no one should be treated roughly by staff]." During an interview with the facility Director of Nursing (DON) and Administrator on 1/18/13 at 4:00 p.m., they indicated they had suspended the CNA while they conducted an investigation of abuse for Resident #33. During an interview with the facility Administrator on 1/22/13 at 1:30 p.m., the Administrator indicated that after the investigation was conducted the CNA decided to resign rather than be "written up" and placed on a "final notice" status. A facility policy, with multiple dates of		are identified as having potential to be affected. The facility will implement a zero tolerance policy for any form of abuse. This policy will be reviewed with staff during the inservice on 2/15/2013. The facility will make a statement about its zero tolerance policy that will be included in each resident's admission packet. The admissions committee will evaluate each inquiry for abuse risk. The facility strives to provide a calming atmosphere with interventions such as music, staff intervention when needed, activities, and animal therapy. The Quality Assurance Committee will meet monthly to discuss the effectiveness of interventions to reduce the risk of abuse. Completion Date 2/23/2013ADDENDUM A copy of our Zero Tolerance Policy will be included in the orientation packet for all new employees, and will be reviewed with new employees as part of their orientation. New employees will sign an acknowledgement that they have received, read and understand this policy.	

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	revision, most recently 2/14/2012, titled Abuse Prohibition Policy/Procedure indicated..."It is the policy of Friendship Healthcare to keep its residents free from abuse, neglect, ..."			
	2. In an interview with the Health Facility Administrator on 1/22/13 at 12:15 p.m., he indicated an incident had occurred on 1/20/13 at 2:30 p.m., in the front lobby of the facility. The incident involved Resident #54 and Resident #53. Resident #54's clinical records were reviewed on 1/22/13 at 1:45 p.m. Resident # 54's diagnoses included schizophrenia and seizure disorder. Resident #53's clinical records were reviewed on 1/22/13 at 2:00 p.m. Resident #53's diagnoses included Diabetes Mellitus Type II,			

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	hypothyroidism, hyperlipidemia, anemia, peripheral neuropathy, hypertension and peripheral vascular disease. Review of the report dated 1/20/13 at 2:30 p.m., indicated Resident #53 approached Resident #54 and made an unknown accusation to Resident #53 and hit her on the arm. Resident #53 was removed safely from the other resident without injury. Resident #54 was transported to an acute care hospital for evaluation and treatment. Resident #54 was admitted to the acute care hospital for treatment and did not return to the facility. In an interview with Resident #53 on 1/22/13 at 10:45 a.m., she indicated the staff had informed her that Resident #54 had gone to the hospital for treatment. Resident #53 indicated she was not fearful living at the facility and was, "fine." A review on 1/22/13 at 12:15 p.m., of a documentation entitled, "Facility Incident Reporting Form" initial report indicated information as documented above. A review of a facility policy entitled, "Abuse Prohibition Policy/Procedure"			

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	provided by the Healthcare Facility Administrator upon entrance on 1/14/13 at 4:00 p.m., indicated, "It is the policy of Friendship Healthcare to keep its residents free from abuse, neglect... In the event of an incident the following procedure will be followed." The policy had been revised on 2/14/2012. 3.1-27(a)(l)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review the facility failed to keep a resident protected after a report of abuse for 1 of 6 residents reviewed for abuse in a sample of 6 residents who met the criteria for abuse. Resident #33. Findings Include: During an interview with Resident #33 on 1/18/13 at 1:30 p.m, Resident #33 indicated he was, "pulled and pushed too hard" by a CNA (Certified Nurses Assistant). Resident # 33 indicated that when CNA #12 rolled him over to help him clean up, she pushed him so hard that he banged his knee on a nearby window sill. Resident #33 showed a bruise on his leg and indicated it was very sore. Resident #33 indicated this made them feel very bad and indicated "he didn't want to be a burden, but wouldn't ask for help if he didn't need help [indicating no one should be treated roughly by staff]." He indicated that he was, "a big guy" and indicated, "I don't want	F0226	As always, this facility takes allegations of abuse very seriously and strives to make each one of our residents safe. We continue to report those allegations as outlined by law. In this population, intervention with all allegations are at times challenging due to the accuracy of the informer. The facility assures that all allegations are investigated and appropriate action has been done, including separation of the resident from the alleged threat, and prompt suspensions and reporting. The facility does the appropriate screening of applicants through state licensing agencies and the Indiana State Police. As with Resident #33 the C.N.A. was suspended as soon as the resident reported the incident. She was not allowed to return to work. She resigned instead of accepting termination. This was also reported to ISDH. All residents in the facility are identified as having potential to be affected. The facility will implement a zero tolerance policy for any form of abuse. This policy will be reviewed with staff during the inservice on 2/15/2013. The	02/23/2013

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	to get nobody in trouble, but it's not ok to treat people like that." Resident #33 also indicated that after he reported to the nurse that was working at the time of the incident, CNA #12 came back into his room and yelled at him, calling him a, "liar." During an interview with the facility Director of Nursing (DON) and Administrator on 1/18/13 at 4:00 p.m., they indicated they had immediately suspended CNA #12 and had conducted an investigation of abuse for Resident #33. During an interview with the facility Administrator on 1/22/13 at 1:30 p.m., the Administrator indicated that after the investigation was conducted, CNA #12 decided to resign rather than be, "written up" and placed on a, "final notice" status. A facility policy, with multiple dates of revision, most recently 2/14/2012, titled Abuse Prohibition Policy/Procedure indicated..."It is the policy of Friendship Healthcare to keep its residents free from abuse, neglect, ..." 3.1-28(a)		facility will make a statement about its zero tolerance policy that will be included in each resident's admission packet. The admissions committee will evaluate each inquiry for abuse risk. The facility will plan periodic inservices on verbal responses to resident needs and offer counsel with facility psychologist. Also, the staff is and has been encouraged to notify their supervisor in times of undue stress. The times that might lead them to act in a way that might not be professional. We will offer change in assignment or time off from work. These issues will be reviewed in the inservice on 2/15/2013 The Quality Assurance Committee will meet monthly to discuss the effectiveness of interventions to reduce the risk of abuse. Completion Date 2/23/2013ADDENDUM Staff education regarding stress and staff burnout will be included in the orientation of all new employees. New employees will be provided with a handout that outlines the available interventions to prevent burnout and reduce stress, including change of assignment, visit with the facility psychologist, or talking with department head.	

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F0241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review the facility failed to maintain a resident's dignity by maintaining privacy and having talked in a loud manor to a resident for 2 of 3 residents reviewed for dignity in a sample of 3 residents who met the criteria for dignity. Residents #27 and #59. Findings Include: 1)During a wound care observation for Resident #27 on 1/22/13 at 11:00 a.m., the facility Wound Nurse left Resident #27's buttock exposed when he opened Resident #27's door and went outside the room to get something from a supply cart. Resident #27's door was completely open and no privacy curtain was pulled to maintain Resident #27's privacy. During an interview with the Wound Nurse on 1/22/13 at 11:15 a.m., he indicated he didn't feel that Resident #27 was exposed or violated as there	F0241	The treatment nurse has been counseled on dignity and the facility policy regarding appropriate provision of privacy of Resident #27 during care. The C.N.A. has been counseled on the appropriate demeanor and responses to a resident's needs, including Resident # 59. All residents in the facility are identified as having potential to be affected. An inservice on dignity will be held on 2/15/2013. We will discuss employee behavior and empathy toward others. The facility privacy policy will be reviewed. Upon hiring, each department head will meet with the new employee and review the privacy policy and discuss the appropriate demeanor toward the resident. Additionally, this is in the employee handbook that each new employee receives. Monthly, a C.N.A. meeting will be held with the Administrator and Director of Nursing to discuss privacy and behavior issues. Monthly, a licensed nurse meeting will be held with the Administrator and Director of Nursing to discuss privacy and	02/23/2013

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	was no one staying in the room directly across the hall way from Resident #27's and no traffic in the hall way at the time. 2)During an observation of South Hall on 1/23/13 at 4:50 p.m., Certified Nurses Assistant (CNA) #2 was observed to respond to Resident #59's request for assistance in a loud manor having stated, "I ' m coming! I heard you! I ' m doing too much!" During an interview on 1/23/13 the facility Director of Nursing (DON), Assistant Director of Nursing (ADON), and Administrator at 5:15 p.m., indicated they would conduct an investigation of CNA #2 speaking to Resident #59 in a loud manor. During an interview on 1/24/13 at 2:00 p.m., with the facility MDS (Minimal Data Set) Coordinator, a policy for maintaining residents dignity was requested. The MDS Coordinator indicated the information was in the handbook they provide to each employee. A review of the facility Friendship Healthcare Handbook on 1/25/13 at 1:45 p.m., indicated "The resident has the right to be cared for in a manner and in an environment that maintains		behavior issues. The department heads have been notified and they are responsible to monitor staff behavior on daily rounds, and are required to intervene when any inappropriate behavior is seen or suspected. Inservices on Resident Rights, including privacy and dignity will be scheduled on a regular basis. The privacy policy will be reviewed in Quality Assurance meeting on 2/21/2013. Completion Date 2/23/2013	

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	or enhances each resident's dignity and respect in full recognition of his or her individuality." 3.1-3(t)			

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F0253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview the facility failed to maintain a sanitary interior in that there was a constant foul urine odor in resident rooms that could be detected from the hallway of 2 of 17 resident sampled rooms. (room numbers 7 & 8) Findings include: During initial tour on 1/14 /13 beginning at 11:00 a.m., a foul urine odor was notable at the end of the corridor near the exit door. Immediately upon entering resident room # 7, the odor of urine was very strong in the room. Observation on 1/15/13 at 11:00 a.m., a odor of urine was notable about midway of the corridor of resident rooms. Upon standing outside resident room # 7 the foul urine odor was stronger. Observation on 1/16/13 at 2:15 p.m., a odor of urine was notable about midway of the corridor of resident rooms. Upon standing outside	F0253	Resident rooms North 7 and North 8 have been deep cleaned as per housekeeping schedule. A resident residing in North room 7 has a neurologic condition that prevents her from detecting incontinence. We have implemented a daily shower routine for this resident and a toileting program which consists of reminding her to toilet. She is able to toilet herself independently. We have also provided incontinent briefs for this resident's use. For the resident residing in North room 8 we have implemented a chlorifil preparation for her colostomy. We have also implemented a daily bathing routine for her. Housekeeping will continue to check these rooms each day for odors and implement cleaning as needed. All residents in the facility are identified as having potential to be affected. Housekeeping Supervisor will check these rooms each day and report any odors to nursing staff for intervention to eliminate odors. This procedure will be reviewed in inservice on 2/15/2013. All department heads will monitor the facility daily for odors and	02/23/2013

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	resident room # 7 the foul urine odor was stronger. During interview on 1/16/13 at 10:30 a.m., the Licensed Practical Nurse # 3 present, during a corridor walk through, indicated that she could also smell the urine odor and that it was very strong. During interview on 1/18/13 at 11:00 a.m., the facility Maintenance Director indicated that the administrator ask him to spray the hallway with Fabreeze air freshener, because the residents on the hall were complaining about the smell. An Environmental Tour on 1/24/13/ at 11:40 a.m., with Maintenance and Housekeeping /Laundry Supervisors present, indicated; A strong urine odor was notable in the corridor outside resident rooms 7. Upon entering resident room # 7 the foul urine odor became stronger. A strong urine odor was notable in the corridor outside resident rooms 8. Upon entering resident room # 8 the foul urine odor became stronger. During interview at the time with Housekeeping /Laundry Supervisor,		report to staff for intervention if detected. The QA Committee will also review the routine and implement any other corrective measures as needed to keep the facility free of odors. Completion Date 2/23/2013	

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	confirmed a noticeable urine odor in the corridor outside resident rooms # 7 & 8 and upon entering the resident rooms the odor was stronger. 3.1-19(f)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review the facility failed to ensure that 3 of 20 residents, in a sample of 37 who met the criteria for requiring Care Plans, had Comprehensive Care Plans developed for identified Care Areas. Residents #8, #41 and #4. Findings include: 1. Resident #8 was observed in her room on 1/14/13 at 1:30 p.m. The resident's left hand was observed to have a contracture (abnormal	F0279	Resident 8 was offered a range of motion program for her left hand but she was not interested in participating. We have written a care plan addressing this issue and will periodically be reminded that range of motion services are available if she changes her mind and wishes to receive them. Resident 41 now has a care plan addressing her urostomy. Resident 4 now has an activities care plan. All residents in the facility are identified as having potential to be affected. The Care Plan Committee has created a head to toe assessment form which will be used at each care	02/23/2013

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	shortening of muscle tissue rendering the muscle highly resistant to passive stretching). No splint was observed. A review on 1/22/13 at 11:39 a.m., of Resident #4's clinical record, indicated she had admitting diagnoses which included but not limited to: diabetes mellitus, paranoid schizophrenia, depression, hemiplegia, hemiparesis, hemiplegia unspecified, peripheral neuropathy, hypertension, CVA [cerebral vascular accident], and osteoporosis. 1/23/13 10:30 a.m., a review of Resident #8's clinical record indicated no Care Plan had been developed or implemented to address ROM [Range of Motion] for the resident's left hand contracture. 2. A review of Resident #41's clinical record on 1/22/13 at 9:30 a.m., indicated diagnoses including but not limited to, DM [diabetes mellitus], schizophrenia, paraplegia, CHF [congestive heart failure], anemia, depression, anxiety, history of DVT [history of deep vein thrombosis], hypercoagulation, obesity, SOB [shortness of breath], cellulitis, urinary tract infection, leukocytosis, and paraplegia.		plan review for each individual resident. This will be used as a tool for the team to assess all areas of needs, including ostomy and restorative needs. The care plan assessment forms be reviewed by the Director of nursing or designee weekly for no less than four weeks to ensure the effectiveness of our new process. When 100% compliance is achieved three weeks in a row, auditing will reduce to monthly X no less than three months. When 100% compliance is achieved three months in a row, auditing will reduce to quarterly and will remain quarterly on an ongoing basis. Results of these audits will be discussed at QA Meeting no less than quarterly. The MDS Coordinator, Director of Nursing and Administrator are responsible for compliance. Completion Date 2/23/2013ADDENDUM Resident # 8 will be reminded quarterly that restorative nursing programs are available should she wish to participate. Resident # 8 was offered therapy, restorative nursing, and splinting on 10/10/2012, 11/12/2012 and 2/11/2013 and consistently refused each intervention that was offered every time it was offered to her.	

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	On 1/22/13 at 2:30 p.m., in an interview with the Wound Nurse, he indicated the resident had her bladder removed in September of 2012. Her ureters from both kidneys were rerouted to a stoma in her abdomen where urine drained into a bag adhered to her stoma (urostomy). On 1/22/13 3:00 p.m., an observation of Resident #41's abdomen indicated a stoma located in her lower right abdomen. A bag adhered to her abdomen had clear yellow urine in it. A record review on 1/22/13 at 3:30 p.m., indicated no Comprehensive Care Plan had been developed or implemented for care of the resident's stoma. In an interview with the ADON [Assistant Director of Nursing] on 1/22/13 at 4:00 p.m., she indicated no Comprehensive Care Plan had been written or implemented for stoma care for the resident. 3) Clinical records for Resident #4 were reviewed on 1/23/13 at 4:00 p.m. Diagnoses included but were not			

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	limited to, brain damage related to alcohol and drug abuse, and severe anxiety. During an interview on 1/24/13 at 11:00 a.m., with the Activities Assistant, she indicated she does many one on one visits with Resident #4, that she enjoys activities, visits with her family every day, and attended many activities previously, but she had been less involved related to recent decline in health condition and hospice placement. A Care Plan for Resident #4 was requested of the Assistant Director of Nursing (ADON) on 1/24/13 at 11:30 a.m. During an interview with the ADON on 1/24/13 at 12:30 p.m., she indicated there was no care plan for Resident #4's activities, however one was created after it was requested. 3.1-31(c)(3)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview the facility failed to provide Restorative Range of Motion Services as care planned for 2 of 6 residents in a sample of 6 residents that met the criteria for range of motion. The facility also failed to follow a physicians order for blood sugar monitoring for 1 of 10 residents reviewed for Unnecessary Medications in a sample of 10 residents. This involved Resident #'s 9, 10, and 29. Findings Include: 1) Clinical Records for Resident #9 were reviewed on 1/22/13 at 10:00 a.m. Diagnoses included but were not limited to, ms (multiple sclerosis, a disease that affects the brain and spinal cord), anxiety disorder, depression, and seizure disorder. A facility Plan of Care dated 12/17/12 indicated Resident #9 is, "Unable to independently move bilateral (both)	F0282	1) Restorative program availability willbe on a full time basis with the use of a full time restorative CNA for thepurpose of initiating, completing and capturing restorative programed minutesas well as maintaining scheduled weights as the only tasks assigned. A parttime restorative CNA will be available for the weekend hours with the purposeof initiating, completing and capturing restorative programed minutes as wellas maintaining scheduled weights as the only tasks duly assigned. 2) All residents who were/are on therestorative program in the facility are identified as having potential to beaffected. 3) CNA 's who are designated to beassigned as full time/and or part time restorative aides will be educated bytherapy department on proper restorative policies and procedures as well asproper documentation of such activities. 4) The DON or designee will audit therestorative CNA's for restorative completion and accuracy of documentationthree times a week for the first 30 days, two times a week for the next thirtydays and once a week for the duration of 90 days total. 5)	02/19/2013

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	legs due to paraplegia related to MS" (Multiple Sclerosis), "Resident will tolerate three sets of 20 repetitions of Passive Range of Motion to bilateral legs". "Perform Passive Range [where staff assists the resident move their joints] of Motion on hips, knees, and ankles doing 3 sets of 20 repetitions." A facility Rehabilitation/Restorative Service Delivery Record dated for December 2012, indicated Resident #9 started on the facility's "Restorative" program 12/17/2012. The form indicated, "Perform Passive Range of Motion to bilateral legs (hips, knees and ankles) 3 sets of 20 repetitions to each joint, six to seven days per week." The form indicated resident received Range of Motion Services (ROM) on December 19, 20, 22, 23, 24, 29, 30, and January 5, 6, 8, 9,12,13,19, and offered but Resident #9 refused services on the 20th, indicating Resident #9 received Restorative Range of Motion Services 7 times in 2 weeks in December 2012, and 8 times in 3 weeks in January 2013, missing more than half of the required times for receiving required range of motion services. During an interview with the facility Minimal Data Set (MDS) Coordinator		Date of Completion 2/19/13 Tag F282 ADDENDUM: Policy andprocedures pertaining to restorative program will be placed in Nursing policy proceduremanual located in DON's office. Another copy of restorative policy andprocedures will be placed in the restorative binder located at the nurses'station along with weekly updated restorative list of individuals currentlyactive on restorative programADDENDUM On 1/30/2013, our Physical Therapy manager trained all C.N.A.s on our restorative nursing programs. Additionally, all newly hired C.N.A.s will be trained on restorative nursing program and techniques as part of their orientation. In the event we are short staff or there are call ins, or for any other reason our designated Restorative Aide is unable to provide nursing restorative services that are care planned, each C.N.A. will be held responsible to provide restorative nursing services to each resident to whom they are assigned.	

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	on 1/23/12 at 3:00 p.m., he indicated they have had to, "pull" the person used to provide Restorative Services to work as a CNA (Certified Nurses Assistant) to provide care for residents because the facility had been short staffed. During an interview with CNA #9 on 1/24/13 at 9:30 a.m., she indicated she had been pulled away from the Restorative Services program to help with resident care needs because the facility was short staffed. During an interview with the facility Minimal Data Set (MDS) Coordinator on 1/24/12 at 2:00 p.m., he indicated there was no policy and procedure in regards to Restorative or Range of Motion Services. 2) Clinical Records for Resident #10 were reviewed on 1/22/13 at 1:00 p.m. Diagnoses included but were not limited to diabetes mellitus (a condition affecting blood sugar levels). Resident #10's clinical record indicated a physicians order started 3/28/11 to, "Check blood sugar two times daily, call MD [medical doctor] if			

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	below 70 or above 400." The record indicated a high blood sugar level of 416 on 11/2/12. The record also indicated that the blood sugar reading to be done daily at 4:00 p.m., was not done on 11/29/12, 12/13/12, nor 12/24/12. A request for further information in regards to the blood sugar monitoring was requested of the Assistant Director of Nursing (ADON) on 1/22/13 at 2:30 p.m. During an interview with the ADON on 1/23/13 at 9:00 a.m., she indicated no further information was available for the blood sugar monitoring. During an interview with the facility Minimal Data Set (MDS) Coordinator on 1/24/12 at 2:00 p.m., a facility policy for Diabetic Monitoring was requested. A facility policy dated 2005, and titled, "Blood Sugar Monitoring" indicated, "If blood glucose level is above or below normal range, document the time the physician was notified" and to, "Check physicians order for blood sugar testing frequency."			

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	3) On 1/24/13 at 11:40 a.m., during an interview with Resident # 29 they indicated the facility staff had not offered to do the Range of Motion, put their splint on their hand at night, nor walk them as the therapist's plan indicated. On 1/24/13 at 2:00 p.m., a review of the Rehabilitation/Restorative Service Delivery Record for Resident # 29 indicated they were to receive: 1) Assist resident to transfer from wheelchair to bed and from bed to wheelchair using gait belt and hemi walker. Two sets of 5 repetitions six to seven days per week. Maintain standing position for three minutes each rep. 2) walk resident 50 feet using gait belt and hemiwalker twice, six to seven days per week. 3) Perform Passive Range of Motion to all joints of Right arm (shoulder, elbow, wrist) two sets of 10 repetitions to improve ADL independence. The documentation indicated that resident #29 received Restorative Service on 1/19/13 as indicated.			

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	On 1/20/13 Restorative Service were refuse by the resident. On 1/21/13 Restorative Service were not offered. On 1/22/13 Restorative Service were not offered. On 1/23/13 Restorative Service were not offered. On 1/24/13 Restorative Service were revived after interview with resident. During an interview with the Assistant Director of Nursing (ADON) on 1/24/13 at 2:30 p.m., she indicated due to 6 CNA's being removed from the schedule, the Restorative Aide was reassigned to direct resident care. Restorative service were not provided on 1/21/13, 1/22/13, nor 1/23/13. 3.1-35(g)(2)			

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F0318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review the facility failed to ensure Range of Motion Services were provided for 1 of 3 residents reviewed for provision of Range of Motion services in a sample of 37 residents. Resident #8. Findings include: Resident #8 was observed in their room on 1/14/13 at 1:30 p.m. The resident's left hand was observed to have a contracture (abnormal shortening of muscle tissue rendering the muscle highly resistant to passive stretching). No splint was observed. A review on 1/22/13 at 11:39 a.m., of Resident #8's clinical record indicated they had admitting diagnoses including but not limited to; diabetes mellitus, paranoid schizophrenia, depression, hemiplegia, hemiparesis, hemiplegia unspecified, peripheral neuropathy, hypertension, cva [cerebral vascular accident], and	F0318	1) CNA 's who are designated to beassigned as full time/and or part time restorative aides will be educated bytherapy department on proper restorative policies and procedures as well asproper documentation of such activities. 2) DON or designee will maintain monthlynotes explaining progress or decline based on observation and or interviewsfrom assigned restorative staff and or residents participating in restorativeprogram. 3) DON or designee will provide accuratedocumentation monthly detailing goals for the following month and explanationfor any refusals and or discharge from restorative program. As well asimplementing a full screening tool to assess for ROM needs. 4) All residents who were/are on therestorative program in the facility are identified as having potential to beaffected. 5) The DON or designee will audit therestorative CNA's for restorative completion and accuracy of documentationthree times a week for the first 30 days, two times a week for the next thirtydays and once a week for	02/19/2013

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	osteoporosis. On 1/23/13 at 9:10 a.m., in an interview the Restorative Aide indicated the resident was not on the list of residents receiving Restorative services. In an interview on 1/23/13 at 9:30 a.m., the MDS [Minimum Data Set] Coordinator provided a screening document from the Therapy Department dated 11/12/12 which indicated Resident #8 indicated, "you can't help me." No further documentation was provided to indicate Resident #8 was reassessed or provided ROM [Range of Motion] or restorative services. 3.1-42(a)(2)		the duration of 90 days total. End of month notes willbe completed by DON or designee stating any changes of goals due to progressionor discharge from restorative program. 6) Date of Completion 2/19/13 ADDENDUM Resident # 8 was offered therapy, restorative nursing, and splinting on 10/10/2012, 11/12/2012 and 2/11/2013, and consistently refused each intervention that was offered every time it was offered to her. We will continue to offer these services quarterly to keep her informed that they are available to her.	

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation and interview the facility failed to maintain a safe environment for residents. This had the potential to affect 46 of 46 residents who reside in the facility. Findings Include: During an observation on 1/17/13 at 3:00 p.m., of South Hall; 2 types of air fresheners were noted on top of a box covering the hallways thermostat, in reach of any resident who could walk or have a grabber type of device. One air freshener was a "Renuzit" brand gel air freshener that had apples on the outside cover. The label indicated, "keep out of reach of children and animals." The label indicated that the substance was made from a renewable gellant material, water, and perfume. The other container was clear glass, with red liquid in it, no instructions nor label. During an interview with the facility Chief Executive Officer (CEO) on	F0323	Our facility does not purchase “Renuzit” or other gel type air fresheners as part of its environmental cleaning chemicals. This item was purchased by a resident. Unfortunately it was placed there by the resident who purchased it, and there was no MSDS sheet available. The air fresheners noted in the 2567 have both been removed and disposed of. All residents in the facility are identified as having potential to be affected. During the admission process a statement will be given to all new residents that chemicals, air fresheners, etc. are not allowed for use unless approved by the QA Committee and the proper MSDS obtained. A resident council meeting will be requested on 2/19/2013 to inform current residents of this policy. All environmental chemicals will be in a locked area. MSDS sheets for approved chemicals are held by the housekeeping and maintenance supervisors. The housekeeping supervisor is responsible to check halls and rooms for unapproved chemicals and remove as needed.	02/23/2013

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	1/17/13 at 3:05 p.m., she indicated the air fresheners belonged to a resident and were probably placed there when the room was being cleaned. She indicated the air fresheners were normally not there and were not supposed to be there. During an interview on 1/24/13 at 2:00 p.m., with the facility MDS (Minimal Data Set) Coordinator a Material Safety Data Sheet (MSDS) was requested for the air fresheners. The facility was unable to provide a Material Safety Data Sheet for either one. A facility policy in regards to safety was requested on 1/24/13 at 2:00 p.m. An undated facility policy titled, "Material Safety Data Sheet (MSDS) Policy" indicated "Supervisor are responsible to provide department-specific training on hazardous chemicals for their employees." 3.1-45(a)(l)		Housekeeping and maintenance supervisors will review all MSDS for currently used chemicals and submit to QA on 2/21/2013, thus confirming all MSDS are available on all chemicals used in the facility. Completion Date 2/23/2013	

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F0353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview, and record review the facility failed to provide nursing personal in sufficient numbers to provide Rehabilitations/Restorative Services as ordered/care planned for 2 of 2 residents. (resident #9, 29) Finding include: 1. On 1/24/13 at 11:40 a.m., during interview with Resident #29 indicated the facility staff had not offered to do the Range of Motion, put their splint	F0353	1) Restorative program availability willbe on a full time basis with the use of a full time restorative CNA for thepurpose of initiating, completing and capturing restorative programed minutesas well as maintaining scheduled weights as the only tasks assigned. A parttime restorative CNA will be available for the weekend hours with the purposeof initiating, completing and capturing restorative programed minutes as wellas maintaining scheduled weights as the only tasks duly assigned. 2) All residents who were/are on	02/19/2013

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	on their hand at night, nor walk them as the therapist indicated. At 2:00 p.m. on 1/24/13, a review of Rehabilitation/Restorative Service Delivery Record for resident # 29 indicated they were to receive: 1) Assist resident to transfer from wheelchair to bed and from bed to wheelchair using gait belt and hemi walker. two sets of 5 repetitions six to seven days per week. Maintain standing position for three minutes each rep. 2) walk resident 50 feet using gait belt and hemiwalker twice, six to seven days per week. 3) Perform Passive Range of Motion to all joints of Right arm (shoulder, elbow, wrist) two sets of 10 repetitions to improve ADL independence. The documentation indicated the resident received Restorative Service on 1/19/13 as indicated. On 1/20/13 Restorative Service were refuse by the resident. On 1/21/13 Restorative Service were not offered. On 1/22/13 Restorative Service were not offered. On 1/23/13 Restorative Service were not offered. On 1/24/13 Restorative Service were revived after interview with resident.		therestorative program in the facility are identified as having potential to beaffected. 3) CNA 's who are designated to beassigned as full time/and or part time restorative aides will be educated bytherapy department on proper restorative policies and procedures as well asproper documentation of such activities. 4) The DON or designee will audit therestorative CNA's for restorative completion and accuracy of documentationthree times a week for the first 30 days, two times a week for the next thirtydays and once a week for the duration of 90 days total. 5) Date of Completion 2/19/13 ADDENDUM On 1/30/2013, our Physical Therapy manager trained all C.N.A.s on our restorative nursing programs. Additionally, all newly hired C.N.A.s will be trained on restorative nursing program and techniques as part of their orientation. In the event we are short staff or there are call ins, or for any other reason our designated Restorative Aide is unable to provide nursing restorative services that are care planned, each C.N.A. will be held responsible to provide restorative nursing services to each resident to whom they are assigned.	

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	Review of Resident #29's clinical records were reviewed on 1/24/13 at 1:30 p.m. Current diagnoses included, but were not limited to cerebrovascular accident (CVA) with right sided hemiplegia (paralysis). During an interview with the Assistant Director of Nursing (ADON) on 1/24/13 at 2:30 p.m., she indicated that due to 6 Certified Nursing Assistants (CNA) being removed from the schedule, the Restorative Aide was reassigned to direct resident care, so restorative service were not provided on 1/21/13, 1/22/13, nor 1/23/13. On 1/14/13 at 3:00 p.m., the ADON provided the employee schedule for January 2013. A review of the schedule on 1/24/13 at 9:00 a.m., indicated there was 1 Restorative CNA scheduled for week-ends only during the month of January. On 1/24/13 at 2:30 p.m., a requested updated schedule for January 2013, was provided by the Administrator. The schedule indicated 6 CNA's and 1 LPN had been removed from the schedule. The facility had hired 6 CNA's but they had to go through orientation/training . They had no			

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	restorative aide on the schedule. 3.1-17 (a)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review the facility failed to ensure	F0441	LPN #1 was counseled and an individual inservice was given on	02/23/2013

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	Infection Control Policies and Procedures were followed as evidenced by improper handwashing and improper screening of new employees for Tuberculosis. This had the potential to affect 46 of 46 residents residing in the facility. Findings include: 1. On 1/18/13 at 11:30 a.m., LPN [Licensed Practical Nurse] #1 instilled one drop of Ketorolac Solution 0.5% in resident #54's left eye without washing their hands before donning gloves. They then did not wash their hands after doffing the gloves. At 11:36 a.m., without washing their hands, they donned gloves, entered resident #54's room and instilled 1 drop of Tobramycin Solution 0.3% in the resident's left eye, doffed their gloves and returned to the medication cart without washing their hands. At 11:42 a.m., LPN #1 donned clean gloves without washing their hands. They proceeded into Resident #54's room and instilled 1 drop of Prednisone Opthalmic Suspension 1% in the resident's left eye. They proceeded to doff their gloves and without washing their hands, returned to the medication cart and resumed administering medications to other residents. A review of a document entitled,		eye drop administration and hand washing. The employee files cited have been reviewed, and those that are still currently employed at the facility have been brought up to date with their first and second step PPDs. All residents in the facility have been identified as having potential to be affected. A staff nurse meeting will be held on 2/20/2013 to inservice all nursing staff on hand washing and infection control. The Director of Nursing will present this inservice. A log sheet will be created to monitor all employee PPD's. The care plan coordinator will monitor the PPD log. The care plan coordinator will report to the QA Committee on a monthly basis on the compliance of getting first and second step PPDs done for new employees. Completion Date 2/23/2013ADDENDUM Staff education on hand washing and infection control will be provided to all new staff members during orientation. As part of this training, new employees will be provided with a copy of Healthcare Associated Infections as an educational tool to prevent spread of infections.	

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	"Handwashing Policy/Procedure" updated on 3/28/08, indicated the purpose of the policy was to, "decrease the risk of transmission of infection by appropriate handwashing." Point II entitled, "Waterless Handwashing Products" indicated in point B., "Waterless handwashing products are not used for skin care treatments or administration of eyedrops." 2. On 1/23/13 at 2:30 p.m., a record review of new employee pre-hire screening forms indicated 5 of 5 new employees did not receive a second step TB [Tuberculosis] test. Employees #4 with a hire date of 10/13/12, #5 with a hire date of 10/25/12, #6 with a hire date of 12/26/12, #7 with a hire date of 12/26/12, and #8 with a hire date of 11/30/12 had all received a first step TB test, but had not received a second step TB within 10 [ten] to 21 [twentyone] days after receiving a First Step P.P.D. An interview with the CEO [Chief Executive Officer] on 1/23/13 4:00 p.m., indicated they were aware that second step Tuberculosis tests were not administered. They indicated, "We are going to have a P.P.D. [Purified Protein Derivative] Party in February and do the whole facility."			

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	3.1-18(k) 3.1-18(l)			

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview, and record review the facility failed to identify and implement a plan of action for the identified concerns of Resident Abuse, Comprehensive Care Plans, and Range of Motion as evidenced by deficient practice care areas. This had the potential to affect 43 of 43 residents residing in the facility. Findings include:	F0520	Our next Quality Assurance Committee meeting is scheduled for 2/21/2013. QA meetings are held monthly in our facility. We will review our policy/procedures and create plans of action to address the following: 1) Abuse Prohibition 2) Comprehensive Care Planning relating to treatments 3) Restorative Services Resident #53 did not return to the facility, removing any further risk of conflict from her. Resident #41 has had a care plan placed in the	02/23/2013

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	1. In an interview with the Health Facility Administrator on 1/22/13 at 12:15 p.m., they indicated an incident had occurred on 1/20/13 at 2:30 p.m. in the front lobby of the facility. The incident involved Resident #54 and Resident #53. They indicated Resident #53 approached Resident #54 and made an unknown accusation to Resident #53 and hit Resident #54 on the arm. Resident #53 was removed safely from the other resident without injury. Resident #54 was transported to an acute care hospital for evaluation and treatment. Resident #54 was admitted to the acute care hospital for treatment and did not return to the facility. 2. On 1/22/13 3:00 p.m., an observation of Resident #41's abdomen indicated a urostomy stoma located in her lower right abdomen. A bag adhered to her abdomen had clear yellow urine in it. A record review on 1/22/13 at 3:30 p.m., indicated no Comprehensive Care Plan had been developed or implemented for care of the resident's stoma. In an interview with the ADON		record to address the urostomy. Resident #8 has been evaluated by the therapy department on 10/12/12, 1/13/13, and 2/11/13, and she continues to refuse therapy and restorative care. A care plan has been placed in her record to address the contracture and her refusal of treatment for it. All residents in the facility are identified as having potential to be affected. The Care Plan Committee has created a head to toe assessment form which will be used at each care plan review for each individual resident. This will be used as a tool for the team to assess all areas of needs, including ostomy and restorative needs. The QA Committee will review the zero tolerance policy for abuse (see also F223). The Care Plan Committee will report to the QA Committee regarding the effectiveness of the head to toe assessment form to identify areas in need of care planning. Completion Date 2/23/2013	

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203	

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	[Assistant Director of Nursing] on 1/22/13 at 4:00 p.m., she indicated no Comprehensive Care Plan had been written or implemented for stoma care for the resident. 3. On 1/23/13 at 9:10 a.m., in an interview with the Restorative Aide, they indicated the resident was not on the list of residents receiving Restorative services. In an interview on 1/23/13 at 9:30 a.m., the MDS [Minimum Data Set] Coordinator provided a screening document dated 11/12/12 from the Therapy Department. Documentation indicated Resident #8 indicated, "you can't help me." No further documentation was provided to indicate the resident was reassessed or provided ROM [Range of Motion] or Restorative services. 3.1-52(b)(2)			