STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TR NEW CARLISLE, IN 46552

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit resulted in an Extended Survey - Immediate Jeopardy. This visit was in conjunction with the Investigation of Complaints IN00234087, IN00239282 and IN00233484. Complaint IN00234087 - Unsubstantiated due to lack of evidence. Complaint IN00239282 - Substantiated. No deficiencies related to this allegation are cited. Complaint IN00233484 - Substantiated. No deficiencies related to this allegation are cited. Survey dates: September 14, 15, 16, 17, 18, 19, 20, & 21, 2017. Facility number: 000427 Provider number: 155672 AIM number: 100275150 Census Bed Type:	F 0000		

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

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	SNF/NF: 72 Residential: 75 Total: 147 Census Payor Type: Medicare: 10 Medicaid: 40 Other: 19 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on September 28, 2017.			
F 0166 SS=D Bldg. 00	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The			

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	grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1),			

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	immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to promptly resolve a concern regarding missing items, to communicate progress related to missing items, and to ensure missing personal items were retrieved or replaced for 1 of	F 0166	Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact or conclusion set forth in the statement of	10/21/2017

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	3 missing item grievances reviewed. (Resident #112). Finding includes: During an interview, on 09/19/17 at 11:18 AM, Resident #112 indicated she has had several items go missing over the past few months, including a charm bracelet with sentimental value. She indicated she had reported them all to staff and has not heard anything about them. During an interview, on 09/19/17 at 2:30 PM, the ADON (Assistant Director of Nursing) indicated there was no specific documentation available regarding the investigation of the lost items. A clinical record review was conducted, on 09/20/17 at 12:00 PM, for Resident #112 and indicated an admission date of 06/28/17. Her diagnoses included, but were not limited to: dementia, hypertension, adjustment disorder, diabetes, insomnia, and anemia. The admission MDS (Minimum Data Set) assessment, dated 07/03/17, indicated a BIMS (Brief Interview for Mental Status) score of 12, mild cognitive impairment.		deficiencies. The plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies. F 166 No residents were adversely affected by this alleged deficiency It is Hamilton's policy to promptly resolve grievances to the satisfaction of the resident and/or representative. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** In order to clarify this allegation, resident #112 resided in our **residential care facility** at the time; "several items had gone missing over the past few months" (Residential or assisted living accommodations are not the subject of CMS	

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	During an interview, on 09/20/17 at 12:13 PM, LPN #5 (Licensed Practical Nurse) indicated she had no documentation regarding the missing items for Resident #112, but was aware of her concern. She indicated the resident had been moved to a new room due to a bed bug issue and all of her belongings were left in her old room and it was unclear to her who had cleaned out the room. During an interview, on 09/20/17 at 12:18 PM, the ED (Executive Director) indicated the facility had returned all of the missing items for Resident #112, but there was no documentation available regarding the missing items or what was done to find them. During an observation, on 09/20/17 at 12:22 PM, the ED interviewed Resident #112 and asked her if she recalled him informing her yesterday that all her items were located. Resident #112 indicated to the ED that she was still missing a charm bracelet and her bottom dentures recently went missing. The ED indicated to her that he could not determine where the charm bracelet was. During an interview, on 09/20/17 at 2:30 PM, the ADON indicated there was no specific policy available for lost items		guidelines). This administrator was working with the resident's responsible party to resolve problem. Family agreed to discard much of the belongings due to the transfer from residential to healthcare. At the date the inspector broached administration about this matter all but two (2) items were recovered. The responsible party and administration had agreed to an amicable monetary restitution prior to this "discovery" by the inspector. Consequently the missing items issue was resolved. No interview was conducted with the responsible party though they were immediately available and present when the ED interviewed him in the presence of the inspector. Secondly, the missing dentures were brought to Hamilton administration's attention the very day the Inspector "discovered" it. Hamilton's policy stipulates administration has five (5)	

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	and the resident and/or family would fill out a grievance form to report missing items and it would be investigated. 3.1-7(a)(2)		working days to resolve grievances once grievance or complaint d is received. A grievance form was started on 9/20/2017 –the day of "discovery" and resolution was achieved on 9/26/2017 to responsible party and resident's satisfaction. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents at the facility have the potential to be adversely affected by this deficient practice. Any resident found to have missing or lost possessions were promptly investigated and resolved to the satisfaction of the resident and/or responsible party ***What measures will be put into place or what***	

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			systemic changes will be made to ensure that the deficient practice does not recur The Social Worker/ designee will be responsible for investigating and documenting all family and resident concerns. Upon receipt of a grievance and/or complaint, the Grievance Officer /designee will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and /or complaint. Documenting the concern(s) on a Concern/Complaint/Grievance form. Social Services will record and maintain all grievances and/or complaints on the Resident Grievance Complaint Log. Resident grievances will be reviewed by the Interdisciplinary Team during daily morning work	

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			day meetings. Any verbal or non-documented concerns will be given to the Grievance Officer for investigation/resolution. The Grievance/Complaint/Concern form will be submitted to the Administrator/Designee for further review within five (5) working days of the event. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** Effective October 21, 2017 a quality-assurance program will be implemented under the supervision of the Administrator/designee. The Administrator /designee will perform the following systemic changes: monitor daily for 30 days the Grievance log. Any unresolved grievances/concerns/complaints not corrected within five (5)	

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			working days will be immediately resolved and the findings of the daily review will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter or until a 95% threshold is met. **The date by which systemic changes will occur: O**ctober 21, 2017	
F 0223 SS=E Bldg. 00	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to prevent staff to resident abuse for 4 of 4 residents	F 0223	*F223* No residence were adversely affected by this alleged deficient practice	10/21/2017

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	reviewed for abuse. (Resident #17, Resident #86, Resident #25 and Resident #16) Findings include: 1. During an interview, on 9/14/17 at 4:00 P.M., Resident #17 indicated on 7/21/17 CNA #2 was pushing her to the assisted living dining room for lunch and there were quite a few people standing in the way by coffee area and CNA #2 wanted to get through. She indicated CNA #2 was just really angry that all the people were in the way that day and hit another resident's chair with her chair. She indicated she was embarrassed when incident occurred because CNA #2 was very angry. The clinical record was reviewed for Resident #17 on 9/14/17 at 2:00 P.M. The diagnoses included, but were not limited to, congestive heart failure, hypertension, and diabetes mellitus. The quarterly MDS (Minimum Data Set) assessment, dated 7/2/17, indicated Resident #17 had a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact, required extensive assist with ADLs (activities of daily living), and was propelled by staff in a wheelchair.		It is the policy and practice of Hamilton Grove to protect and safeguard residents from abuse as defined by 483.12(a): Abuse is the WILLFUL infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish… There were no residents adversely affected by this alleged incident. These particular episodes were self-reported by administration of this facility. The employee was enrolled in our progressive discipline program. *What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.* •□□□□□□□□ For Resident 17, 86, 16, 25 sufficient time has elapsed to preclude the correction of these alleged incidents. However, subsequent interviews with each resident indicates there are no residual psychological effects from these alleged incidents. •□□□□□□□□ CNA #2 is no longer employed by this facility. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient	

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	A combined written statement from FSA (Food Service assistant) #9, FSA #10 and FSA #11, dated 7/21/17, indicated CNA #2 was bringing Resident #17 into the assisted living dining room. One male resident was out to far in his chair and Resident #16 was in wheelchair at the table, leaving a small space to get through. CNA #2 told the male resident to move forward, but he did not understand. CNA #2 stated, "Never mind, stay where you are, if I hit you, I hit you." She then proceeded to push Resident #17 into Resident #16 (the one in the wheelchair). CNA #2 hit the Resident #17's wheelchair into Resident #16's wheelchair and stated, "See, I told you". She then went up to the male resident and shoved him forward making him hit the table. The male resident let out a yell and CNA #2 just walked away. The Follow Up Report, dated 7/24/17, indicated the Administrator had confirmed the allegations. Through interviews with staff and Resident #17, CNA #2 had deliberately pushed Resident #17's wheelchair into the Resident #16's wheelchair. CNA #2 was suspended for 2 days. 2. The clinical record for Resident #86 was reviewed on 9/14/17 at 2:15 P.M.		practice. •□□□□□□□□ Residents who are interviewable will be re-interviewed by October 21, 2017 by the Administrator/designee to ensure no negative outcome is observed. •□□□□□□□□ Residents who are non interviewable family/other representative will receive a QIS questionnaire regarding abuse. •□□□□□□□□ CNA #2 is no longer employed by this facility. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ DON/designee will be responsible to re-inservice healthcare staff regarding resident abuse, recognizing signs and symptoms and the mechanism for reporting witnessed events until Hamilton staff and contracted personnel working in our building have completed this reeducation program by Administrator/designee by Oct 21, 2017. •□□□□□□□□ Alert and oriented residents whose mental acuity is not severely impaired will be interviewed by administration to determine if there is any evidence of maltreatment of residents that either has happened or is currently occurring. •□□□□□□□□ Any reports of allegation of abuse will be immediately reported to ISDH via	

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	The diagnoses included, but were not limited to, congestive heart failure, history of cerebral vascular accident, and depression. The quarterly MDS (Minimum Data Set) assessment, dated 8/30/17, indicated Resident #86 had a BIMS (Brief Interview of Mental Status) score of 14, cognitively intact, and required extensive assist of one person with ADLs (activities of daily living). A written statement from cook #8, dated 8/10/17, indicated Resident #86 asked if CNA #2 could help her to her room, and CNA #2 responded, "Hold on, baby girl, (another CNA) will come help you". A minute later, Resident #86 asked CNA #2 again because the other CNA did not attend her yet. Resident #86 indicated to CNA #2 that she would like to go back to her room because her legs were swelling up and CNA #2 responded, "How can you see that your swollen, your blind". Resident #86 responded that she could feel them. CNA #2 stated to Resident #86, "You are killing me, Smalls. That's what I am should start calling you, Smalls". The dietary staff felt it was abuse and unprofessional. The Incident Report, dated 8/11/17, indicated a dietary aide over heard a		the Electronic incident reporting system. •□□□□□□□□ Staff members who are the subject of a complaint will be immediately removed from any further resident contact until the investigation is completed. •□□□□□□□□ The investigation will include the resident's statement along with any other witness statement albeit resident or staff who may have observed the incident at the time it occurred. In addition, a wider interview process of residents and staff who may have had direct or tangential contact with the identified staff member to determine whether a pattern of mistreatment exists. This information will also be included in the follow-up five-day report. •□□□□□□□□ Any staff member found to have "abused" a resident as outlined by Federal/State guidelines will be immediately terminated. •□□□□□□□□ For non-interviewable resident's responsible parties will be asked to complete a QIS questionnaire concerning any observation of abuse they may have witnessed either against their family member or another resident. These results will be reviewed upon receipt by administration. Any areas of allegation of abuse will be immediately investigated in accordance with facility policy and Federal/State guidelines. •□□□□□□□□ The Administrator	

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	conversation between CNA #2 and Resident #86. Resident #86 had asked CNA #2 for help, CNA#2 allegedly stated, "Hold on, baby girl". She indicated another aide would come help her. Later Resident #86 asked CNA #2 of help because her legs were "swelling" and CNA #2 allegedly stated, "how can you see that, you are blind". Resident #86 replied she could feel it. CNA #2 stated, "You are killing me" in a joking manner along with other statements to this effect. The Immediate Action Taken, on 8/12/17, was CNA #2 was counseled at length regarding appropriate way to address residents. This was the second such situation involving CNA #2. The Follow up, dated 8/12/17, indicated CNA #2 was dismissed from resident contact and counseled. CNA #2 admitted taking liberties by using terms of endearment and inappropriately joking with the resident. Team Member Coaching and Counseling form, dated 8/11/17, indicated CNA #2 had received a counseling session. 3. During an interview, on 9/14/17 at 2:30 P.M., Resident #25 indicated CNA #2 had bullied her and jerked her around. Resident #25 indicated she had been more incontinent recently due to a urinary tract infection and CNA #2 was mean to		and Director of Nursing/designee will review and update the facility's abuse and investigation policy to ensure compliance with all Federal and State Guidelines. •□□□□□□□□ Any deficiencies will be immediately corrected and data reports derived from this task will submitted to the Quality Assurance Committee for further review and recommendations. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ In order to ensure ongoing compliance with resident abuse protocol and safeguard our residents from abuse, DON/designee will be responsible for conducting these interviews of interviewable residents. •□□□□□□□□ For non-interviewable residents a QIS family interview will be sent to at least 25% of non-interviewable resident population. •□□□□□□□□ The Administrator/designee will review the results of these QIS family interviews and immedialty investigate any allegation of "abuse." •□□□□□□□□ These resident and family interviews will be conducted monthly for 90 days then quarterly thereafter. •□□□□□□□□ The results of the aggregate interviews will be reviewed by the Administrator/designee and submitted to the QA committee for further review and	

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	her because she had to ask for more help and had episodes of incontinence. Resident #25 indicated she was afraid of CNA #2, "she sets me in a spin, as soon as I would calm down she would mess with me again". The clinical record for Resident #25 was reviewed on 9/14/17 at 3:00 P.M. The diagnoses included, but were not limited to, depression and hypertension. The quarterly MDS (Minimum Data Set) assessment, dated 6/29/17, indicated Resident #25 had a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact, and required extensive assist of one to two person for ADLs (activities of daily living). The Incident Report, dated 8/14/17, indicated this report was a part of a previous report regarding how CNA #2 talked to residents. Resident 25 had report on 8/11/17 in the Resident Council Meeting that she felt "bullied" by some things that were said to her by CNA #2. The report indicated the administrator had already talked to CNA #2 and they reiterated the need for CNA #2 to guard what she said to residents. The "Prevention Measures Taken" were to continue to work with and monitor this staff member for compliance with		recommendation monthly for 90 days then quarterly thereafter or until a 95% compliance threshold is achieved. **Compliance date: October 21, 2017**	

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	resident interactions. The "Follow Up" indicated the facility would continue to work with CNA #2 to improve her conversations and verbal treatment of residents in a more professional manner. During an interview, on 9/14/17 at 3:30 P.M., the ADON indicated CNA #2 remained employed because the facility administration did not feel she was abusive. During an interview, on 9/14/17 at 4:07 P.M., the ADON indicated she considered the statement from Resident #25 indicating she felt bullied was abuse. During an interview, on 9/16/17 at 10:00 A.M., the Administrator indicated that he does not always do an investigation if the allegation was "cut and dry". He indicated that not all requested incident reports had thorough investigations available or to indicate if each allegation was isolated or widespread. On 9/14/17 at 1:00 P.M., the DON provided the Abuse\Unusual Occurrences policy, dated 8/1/16, and indicated the policy was the one currently being used by the facility. The policy indicated the resident has the right to be free from verbal, sexual, physical and mental abuse... Mental abuse- episodes of			

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	behavior toward a resident which includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation. Verbal abuse- refers to nay use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. Neglect- means failure to provide goods and services to avoid physical harm, mental anguish or mental illness. 3.1-27(a)(1) 3.1-27(b)			
F 0225 SS=K Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or			

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	(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate 3 of 3 staff to resident allegations of abuse and protect residents during an investigation. (Resident #17, Resident #86, Resident #25 and Resident #16) The Immediate Jeopardy began on 7/21/17 when the facility failed to to complete a thorough investigation of an allegation of abuse and protect other residents from potential abuse and during investigation The DON (Director of Nursing) and ADON (Assistant Director of Nursing) were notified of the Immediate Jeopardy at 11:15 A.M. on 9/15/17. The Immediate Jeopardy was removed on 9/20/17, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. The clinical record was reviewed for	F 0225	***F225*** No residence were adversely affected by this alleged deficient practice It is the policy and practice of Hamilton Grove to protect and safeguard residents from abuse as defined by 483.12(a): Abuse is the WILLFUL infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish… There were no residents adversely affected by this alleged incident. These particular episodes were self-reported by administration of this facility. The employee was enrolled in our progressive discipline program. ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ For Resident 17, 86, 16, 25 sufficient time has elapsed to preclude the correction of these alleged incidents. However, subsequent interviews with each resident indicates there are no residual psychological	10/21/2017

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	Resident #17 on 9/14/17 at 2:00 P.M. The diagnoses included, but were not limited to, congestive heart failure, hypertension, and diabetes mellitus. The quarterly MDS (Minimum Data Set) assessment, dated 7/2/17, indicated Resident #17 had a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact, required extensive assist with ADLs (activities of daily living), and was propelled by staff in a wheelchair. A combined written statement from FSA (Food Service assistant) #9, FSA #10 and FSA #11, dated 7/21/17, indicated CNA #2 was bringing Resident #17 into the assisted living dining room. One male resident was out to far in his chair and Resident #16 was in wheelchair at the table, leaving a small space to get through. CNA #2 told the male resident to move forward, but he did not understand. CNA #2 stated, "Nevermind, stay where you are, if I hit you, I hit you." She then proceeded to push Resident #17 into Resident #16 (the one in the wheelchair). CNA #2 hit the Resident #17's wheelchair into Resident #16's wheelchair and stated, "See, I told you". She then went up to the male resident and shoved him forward making him hit the table. The male resident let out a yell and		ill-effects from these alleged incidents. CNA #2 is no longer employed by this facility. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Residents who are interviewable will be re-interviewed by October 21, 2017 by the Administrator/designee to ensure no negative outcome is observed. •□□□□□□□□ Residents who are non interviewable family/other representative will receive a QIS questionnaire regarding abuse. •□□□□□□□□ CNA #2 is no longer employed by this facility. **What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.** •□□□□□□□□ Staff will be re-inserviced regarding resident abuse, recognizing signs and symptoms and the mechanism for reporting witnessed events until Hamilton staff and contracted personnel working in our building have completed this reeducation program by	

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	CNA #2 just walked away. There was no investigation into the abuse directed at Resident #16, the report only included Resident #17. The Follow Up Report, dated 7/24/17, indicated the Administrator had confirmed the allegations. Through interviews with staff and Resident #17, CNA #2 had deliberately pushed Resident #17's wheelchair into the Resident #16's wheelchair. CNA #2 was suspended for 2 days and then returned without any additional supervision or monitoring in place. 2. The clinical record for Resident #86 was reviewed on 9/14/17 at 2:15 P.M. The diagnoses included, but were not limited to, congestive heart failure, history of cerebral vascular accident, and depression. The quarterly MDS (Minimum Data Set) assessment, dated 8/30/17, indicated Resident #86 had a BIMS (Brief Interview of Mental Status) score of 14, cognitively intact, and required extensive assist of one person with ADLs (activities of daily living). A written statement from cook #8, dated 8/10/17, indicated Resident #86 asked if		Administrator/designee by Oct 21, 2017. •□□□□□□□□ Alert and oriented residents whose mental acuity is not severely impaired will be interviewed by administration to determine if there is any evidence of maltreatment of residents that either has happened or is currently occurring. •□□□□□□□□ Any reports of allegation of abuse will be immediately reported to ISDH via the Electronic incident reporting system. •□□□□□□□□ Staff members who are the subject of a complaint will be immediately removed from any further resident contact until the investigation is completed. •□□□□□□□□ The investigation will include the president's statement along with any other witness statement albeit resident or staff who may have observed the incident at the time it occurred. In addition, a wider interview process of residents and staff who may have had direct or tangential contact with the identified staff member to determine whether a pattern of mistreatment exists. This information will also be included in the follow-up five-day report. •□□□□□□□□ Any staff member found to have "abused" a resident as outlined by Federal/State guidelines will be immediately terminated. •□□□□□□□□ For non-interviewable resident's	

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	CNA #2 could help her to her room, and CNA #2 responded, "Hold on, baby girl, (another CNA) will come help you". A minute later, Resident #86 asked CNA #2 again because the other CNA did not attend her yet. Resident #86 indicated to CNA #2 that she would like to go back to her room because her legs were swelling up and CNA #2 responded, "How can you see that your swollen, your blind". Resident #86 responded that she could feel them. CNA #2 stated to Resident #86, "You are killing me, Smalls. That's what I am should start calling you, Smalls". The dietary staff felt it was abuse and unprofessional. The Incident Report, dated 8/11/17, indicated a dietary aide over heard a conversation between CNA #2 and Resident #86. Resident #86 had asked CNA #2 for help, CNA#2 allegedly stated, "Hold on , baby girl". She indicated another aide would come help her. Later Resident #86 asked CNA #2 of help because her legs were "swelling" and CNA #2 allegedly stated, "how can you see that, you are blind". Resident #86 replied she could feel it. CNA #2 stated, "You are killing me" in a joking manner along with other statements to this effect. The Immediate Action Taken, on 8/12/17, was CNA #2 was counseled at length regarding appropriate way to		responsible parties will be asked to complete a QIS questionnaire concerning any observation of abuse they may have witnessed either against their family member or another resident. These results will be reviewed up receipt by administration. Any areas allegation of abuse will be immediately investigated in accordance with facility policy and Federal/State guidelines. •□□□□□□□□ The Administrator and Director of Nursing/designee will review and update the facility's abuse and investigation policy to ensure compliance with all Federal and State Guidelines. •□□□□□□□□ Any deficiencies will be immediately corrected and data reports derived from this task will submitted to the Quality Assurance Committee for further review and recommendations. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ In order to ensure ongoing compliance with resident abuse protocol and safeguard our residents from abuse, DON/designee will be responsible for conducting these interviews of interviewable residents •□□□□□□□□ For non-interviewable residents a QIS family interview will be sent to at least 25% of non-interviewable resident population. •□□□□□□□□ The Administrator/designee will review the results of these QIS family	

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	address residents. This was the second such situation involving CNA #2. The Follow up, dated 8/12/17, indicated CNA #2 was dismissed from resident contact and counseled. CNA #2 admitted taking liberties by using terms of endearment and inappropriately joking with the resident. The written staff statement and incident report were the only documents provided regarding any investigation into this allegation. Team Member Coaching and Counseling form, dated 8/11/17, indicated CNA #2 had received a counseling session. 3. During an interview, on 9/14/17 at 2:30 P.M., Resident #25 indicated CNA #2 had bullied her and jerked her around. Resident #56 indicated she had been more incontinent recently due to a urinary tract infection and CNA #2 was mean to her because she had to ask for more help and has episodes of incontinence. Resident #86 indicated she was afraid of CNA #2, "she sets me in a spin, as soon as I would calm down she would mess with me again". The clinical record for Resident #25 was reviewed on 9/14/17 at 3:00 P.M. The diagnoses included, but were not limited		interviews and immediately investigate any allegation of "abuse." •□□□□□□□□ These resident and family interviews will be conducted monthly for 90 days then quarterly thereafter. •□□□□□□□□ The results of the aggregate interviews will be reviewed by the Administrator/designee and submitted to the QA committee for further review and recommendation monthly for 90 days then quarterly thereafter or until a 95% compliance threshold is achieved. ***Compliance date: October 21, 2017***	

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	to, depression and hypertension. The quarterly MDS (Minimum Data Set) assessment, dated 6/29/17, indicated Resident #25 had a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact, and required extensive assist of one to two person for ADLs (activities of daily living). The Incident Report, dated 8/14/17, indicated this report was a part of a previous report regarding how CNA #2 talked to residents. Resident 25 had report on 8/11/17 in the Resident Council Meeting that she felt "bullied" by some things that were said to her by CNA #2. The report indicated the administrator had already talked to CNA #2 and they reiterated the need for CNA #2 to guard what she said to residents. The Prevention Measures Taken were to continue to work with and monitor this staff member for compliance with resident interactions. The Follow Up indicated the facility would continue to work with CNA #2 to improve her conversations and verbal treatment of residents in a more professional manner. This incident report was the only document provided regarding an investigation into this allegation.			

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	During an interview, on 9/14/17 at 3:00 P.M., the ADON (Assistant Director of Nursing) and DON (Director of Nursing indicated CNA #2 had not been suspended during the allegations with Resident #86 or Resident #25. During an interview, on 9/14/17 at 3:30 P.M., the ADON indicated CNA#2 remained employed because the facility administration did not feel she was abusive. During an interview, on 9/14/17 at 4:07 P.M., the ADON indicated she considered the statement from Resident #25 indicating she felt bullied was abuse. During an interview, on 9/16/17 at 10:00 A.M., the Administrator indicated that he does not always do an investigation if the allegation was "cut and dry". He indicated that not all requested incident reports had thorough investigations available or to indicate if each allegation was isolated or widespread. On 9/14/17 at 1:00 P.M., the DON provided the Abuse\Unusual Occurrences policy, dated 8/1/16, and indicated the policy was the one currently being used by the facility. The policy indicated any staff member who had knowledge of the abuse of a resident, had reasonable cause			

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	to believe that a resident is being or has been abused... shall make an immediate report to the Administrator, DON, or immediate supervisor. Ant staff member who intentionally abuses a resident or permits to exist an abusive situation which results in the physical, emotional, and psychosocial distress of a resident is subject to immediate dismissal. The Administrator/designee shall be responsible for initiating the investigation, including removing the staff member from the facility, in order to assume the resident is protected while the incident is being investigated. The Administrator shall immediately identify and investigate all reportable occurrences, including but not limited to suspected resident abuse, neglect... In house investigation should include a)date/time of administrator/DON notification, b) date/time of investigation, c)records of statement and interviews of eye or circumstantial witnesses, d) date/time of document reviews that preserve data, e) date/time of resident examination occurred, f) date/time steps taken to prevent further abuse, g) Actions taken as a result of the investigation, h) notification of state agencies , of corrective actions, and i) if resident is involved, a resident assessment should be completed.			

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	155672	A. BUILDING 00 B. WING	09/21/2017

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HAMILTON GROVE	31869 CHICAGO TR NEW CARLISLE, IN 46552

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	The Immediate Jeopardy that began on 7/21/17 was removed on 9/20/17 when the facility implemented systematic changes, such as: inservicing all staff members on the policy of reporting abuse allegations but the non-compliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that was not Immediate Jeopardy because of the facility's need to continue in-services. 3.1-28(d)			
F 0226 SS=F Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-			

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	(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on interview and record review, the facility failed to ensure their policy indicated to report immediately to the Administrator. Findings include: On 9/14/17 at 1:00 P.M. the facility Abuse Prohibition policy was reviewed. The policy indicated any staff member who had knowledge of the abuse of a resident, had reasonable cause to believe that a resident is being or has been abused...shall make an immediate report to the Administrator, DON, or immediate supervisor. During an interview, on 9/14/17 at 1:01 P.M., the DON (Director of Nursing) indicated this policy was the one currently being used by the facility. 3.1-28(a)	F 0226	***F226*** No residence were adversely affected by this alleged deficient practice It is the policy and practice of Hamilton Grove to protect and safeguard residents from abuse as defined by 483.12(a): Abuse is the WILLFUL infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish… There were no residents adversely affected by this alleged incident. These particular episodes were self-reported by administration of this facility. The employee was enrolled in our progressive discipline program. ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ For Resident 17, 86, 16, 25 sufficient time has elapsed to preclude the correction of these alleged incidents. However, subsequent interviews with each resident reveals are no	10/21/2017

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			residual psychological ill-effects from these alleged incidents. •□□□□□□□□ CNA #2 is no longer employed by this facility. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Residents who are interviewable will be re-interviewed by October 21, 2017 by the Administrator/designee to ensure no negative outcome is observed. •□□□□□□□□ Residents who are non interviewable family/other representative will receive a QIS questionnaire regarding abuse. •□□□□□□□□ CNA #2 is no longer employed by this facility. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ Staff will be re-inserviced regarding resident abuse, recognizing signs and symptoms and the mechanism for reporting witnessed events until Hamilton staff and contracted personnel working in our building have completed this reeducation program by	

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			Administrator/designee by Oct 21, 2017. •□□□□□□□□ Alert and oriented residents whose mental acuity is not severely impaired will be interviewed by administration to determine if there is any evidence of maltreatment of residents that either has happened or is currently occurring. •□□□□□□□□ Any reports of allegation of abuse will be immediately reported to ISDH via the Electronic incident reporting system. •□□□□□□□□ Staff members who are the subject of a complaint will be immediately removed from any further resident contact until the investigation is completed. •□□□□□□□□ The investigation will include the president's statement along with any other witness statement albeit resident or staff who may have observed the incident at the time it occurred. In addition, a wider interview process of residents and staff who may have had direct or tangential contact with the identified staff member to determine whether a pattern of mistreatment exists. This information will also be included in the follow-up five-day report. •□□□□□□□□ Any staff member found to have "abused" a resident as outlined by Federal/State guidelines will be immediately terminated. •□□□□□□□□ For non-interviewable resident's	

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			responsible parties will be asked to complete a QIS questionnaire concerning any observation of abuse they may have witnessed either against their family member or another resident. These results will be reviewed up receipt by administration. Any areas allegation of abuse will be immediately investigated in accordance with facility policy and Federal/State guidelines. •□□□□□□□□ The Administrator and Director of Nursing/designee will review and update the facility's abuse and investigation policy to ensure compliance with all Federal and State Guidelines. •□□□□□□□□ Any deficiencies will be immediately corrected and data reports derived from this task will submitted to the Quality Assurance Committee for further review and recommendations. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ In order to ensure ongoing compliance with resident abuse protocol and safeguard our residents from abuse, DON/designee will be responsible for conducting these interviews of interviewable residents •□□□□□□□□ For non-interviewable residents a QIS family interview will be sent to at least 25% of non-interviewable resident population. •□□□□□□□□ The Administrator/designee will review the results of these QIS family	

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			interviews and immediately investigate any allegation of "abuse." •□□□□□□□□ These resident and family interviews will be conducted monthly for 90 days then quarterly thereafter. •□□□□□□□□ The results of the aggregate interviews will be reviewed by the Administrator/designee and submitted to the QA committee for further review and recommendation monthly for 90 days then quarterly thereafter or until a 95% compliance threshold is achieved. ***Compliance date: October 21, 2017***	
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on record review and interview, the facility failed to ensure a resident's dignity was maintained when a certified nursing assistant took a bite out of her yogurt before giving it to her for 1 of 6 residents reviewed for dignity. (Resident #17) Findings include:	F 0241	***F241 What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ Resident #17 was interviewed by the DON and Administrator. No negative outcome observed for the alleged deficient practice. During said interview, Resident # 17 stated	10/21/2017

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	A clinical record review was conducted, on 9/19/2017 at 10:06 A.M., for Resident #17 and indicated the resident was admitted on 1/21/17. Her diagnoses included but were not limited to type 2 diabetes with diabetic polyneuropathy, depressive disorder, anxiety disorder, pressure ulcer buttock, rheumatoid arthritis, hyperlipidemia, esophageal reflux, congestive heart failure, neuromuscular dysfunction. A quarterly Minimum Data Set (MDS) assessment, dated 7/2/17, indicated the Brief Interview for Mental Status (BIMS) score, was 15, cognitively intact. During an interview, on 9/19/2017 at 10:09 A.M., Resident #17 indicated CNA (Certified Nursing Aide) #6 took a bite of her yogurt and then handed the container to her including the spoon. After she said something to him, he gave her a different spoon. The Team Member Coaching & Counseling Form dated 9/12/17, written by the Assistant Director of Nursing (ADON) and Director of Nursing (DON) and indicated the CNA was presented a warning regarding the resident reporting he had taken a bite of her yogurt and then gave it to her.		staff #6 took a bite out of her yogurt then gave her another spoon-after which she ate the remaining Yogurt. The resident never indicated during this or subsequent interviews that staff #6 handed the spoon back to her nor did she indicated directing she told the CNA to get another one. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Staff member involved was inserviced by ADON on appropriate infection control, dignity and care issues by 9/12/17. However, the coaching form does not indicate ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ An Inservice was provided by the DON/designee on meal service procedures related to infection control, dignity and handwashing by Oct 21, 2017. •□□□□□□□□ DON/designee will conduct routine rounds to ensure resident care is being provided in a dignified manner. ***How the corrective actions will be monitored to ensure the***	

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	On 9/18/17 a policy was requested, but one was not provided. 3.1-3(t)		***deficient practice will not recur.*** •□□□□□□□□ DON/designee will initiate a Rounds Tool which will be completed at least weekly x 6 months. Administrator/designee will review the Results of the audit tool and present it to the QA Committee monthly for review and recommendations. This will be done monthly for 90 days then quarterly thereafter or until a 95% threshold of compliance is achieved. •□□□□□□□□ Noncompliance with facility rules may result in re-education and/or disciplinary action. Compliance date: October 21, 2017	
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on record review and interview, the facility failed to ensure a resident received 2 showers a week per bathing	F 0242	***F242*** It is the policy of Hamilton Grove to advocate resident's rights to self-determination-right to make	10/21/2017

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	preference for 1 of 1 residents reviewed for choices. (Resident #70) Finding includes: During an interview, on 9/14/17 at 1:55 P.M., Resident #70's husband indicated the resident received sponge baths in bed and did not use the shower due to requiring a hoyer lift for transfers. He indicated Resident #70 had taken showers at home and his preferences for her was to receive a shower. The clinical record for Resident #70 was reviewed on 9/18/17 at 10:00 A.M. The diagnoses included, but were not limited to, diabetes, CVA (cerebrovascular accident), and hemiplegia. The admission MDS (Minimum Data Set) assessment, dated 7/5/17, indicated Resident #70 required extensive assist of 2 people for bed mobility and total dependence for transfers. The Preferences for Customary Routine and Activities, dated 7/5/17, indicated Resident #70's preference for bathing was showers two times per week. During an interview, on 9/19/17 at 11:05 A.M., RN (Registered Nurse) #2 indicated all showers/bed-baths		choices. No residence were adversely affected by this alleged deficient practice ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ Resident #70 (no-interviewable) husband was interviewed to ascertain resident's bathing preference. Care plan was updated to reflect resident choice. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Resident preference interview will be conducted upon admission, preferences will be added to the basic care. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ DON/Designee will conduct resident preference interview upon admission. Preferences will be added to the initial care, updated/revised as needed	

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	completed or refused should be in shower book. She indicated Resident #70 did not have any showers sheets in the shower book and only one bed bath was documented in EHR (Electronic Health Record) on 9/12/17 with all other days indicated no bed bath or shower was given. The Daily Charting for Bathing, dated 6/30/17 through 9/12/17, indicated Resident #70 received a bed-bath on 6/30/17, a shower on 7/14/17, a bed-bath on 8/1/17, a shower on 8/15/17, 8/22/17 and 8/29/17, and a bed bath on 9/12/17. During an interview, on 9/20/17 at 10:00 A.M., the DON (Director of Nursing) indicated Resident #70 should have received at least two showers per week. On 9/19/17 at 2:32 P.M., the policy on bathing was requested from the DON. No policy was provided. 3.1-3(u)(1)		•□□□□□□□□ Residents currently residing in the facility will have preference list reviewed and care plan updated as needed. •□□□□□□□□ Residents shower/bath days will be added to the nurse's treatment administration record. Nurses are responsible to ensure resident shower/bath was offered/completed. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ Administrator/designee will complete rounds with an audit tool at least weekly x 6 months. Results of the audit tool will be provided to the QA Committee for review and recommendations. This will be conducted monthly for 90 days then quarterly thereafter or until a 95% compliance threshold is achieved for review and follow up. •□□□□□□□□ Noncompliance with facility rules may result in re-education and/or disciplinary action. **Compliance date: October 21, 2017**	
F 0243 SS=C Bldg. 00	483.10(f)(5)(i)-(iii)(6)(7) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP			

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	(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (f)(6) The resident has a right to participate in family groups. (f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to provide a designated staff person and ensure meetings were scheduled monthly for resident council. Findings include: The resident council meeting minutes were reviewed, on 09/21/17 at 12:40 PM, and indicated a meeting had not been	F 0243	F243 No residents were adversely affected by this alleged deficient practice It is the policy and practice of Hamilton Grove to conduct and document monthly resident council meetings. ***What corrective action will be accomplished for those residents found to be affected***	10/21/2017

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	held monthly for the past year. Meetings were not conducted for the following months: November 2016, December 2016, January 2017, February 2017, May 2017, and June, 2017. Resident council response forms were not completed for each meeting held. Response forms were only available for August 2016, September, 2016, March, 2017, and August 2017. During an interview, on 09/21/17 at 12:50 PM, the AD (Activities Director) indicated the follow up forms in the meeting book were the only ones available. If they were not in the book, then they were not completed by the department heads and provided to her. She indicated they had not held meetings monthly due to the absence of one staff member. During an interview, on 09/21/17 at 12:54 PM, the Activities Assistant indicated when she was off of work for an extended period of time there were no resident council meetings held. During an interview, on 09/21/17 at 12:58 PM, the ED (Executive Director) indicated there was no policy specific to Resident Council meetings, but they should meet at least monthly.		***by the alleged deficient practice?*** •□□□□□□□□ Residents were interviewed regarding lack of absence of resident council from November 2016 to June 2017. No residents voiced concern regarding council meetings. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken •□□□□□□□□ Residents residing in the facility have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur**. •□□□□□□□□ A Master schedule of resident council meetings was developed for the end of 2017 through December 2017. Residents will receive notice of council meetings via an individual monthly calendar and posted monthly calendar. •□□□□□□□□ Activity Director/designee will be assigned to attend and assist the residents with the council meeting. •□□□□□□□□ A re-inservice for activity staff will be conducted by Activity Director/designee by October 21, 2017. •□□□□□□□□ Current policy on resident council was reviewed by	

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	3.1-3(g) 3.1-3(k)		the Interdisciplinary Team and revised as needed. •□□□□□□□□ Activity Director is responsible for compliance with Resident Council meeting. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ Administrator/designee will review the Minutes of the Council meeting Noncompliance with facility policy will be immediately corrected and re-education and/or disciplinary action may result. ***The date by which the systemic changes will be completed: October 21, 2017.***	
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	155672	A. BUILDING 00 B. WING	09/21/2017

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	comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	Based on record review and interview, the facility failed to ensure a plan of care was developed for a pressure area that progessed to an unstageable wound with appropriate interventions (Resident #70) and for a newly identified Stage 2 pressure area (Resident #115) for 2 of 29 residents reviewed for care palns. Findings include: 1. The clinical record for Resident #70 was reviewed on 9/18/17 at 10:00 A.M. The diagnoses included, but were not limited to, diabetes, CVA (cerebrovascular accident), and hemiplegia. The admission MDS (Minimum Data Set) assessment, dated 7/5/17, indicated Resident #70 was admitted with no pressure areas, required extensive assist of 2 people for bed mobility, and was a total dependence for transfers. The Interdisciplinary Notes, dated 8/2/17 at 7:54 P.M., indicated Resident #70 had a new pressure area on her left heel measuring 4.0 cm (centimeter) x 6.5 cm x 0 that was pale yellow with blue center. Area was found by the CNA (certified nursing aide) when the resident's shoe was removed.	F 0279	***F279 What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ Resident #70 care plan has been developed and will be revised as needed. •□□□□□□□□ Resident #115 no longer resides in the facility ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in the facility with pressure injury have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Care plans are reviewed and revised at least quarterly and with significant changes in resident condition. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ MDS/designee will be responsible to update the care plan for residents with pressure injury. •□□□□□□□□ A re-inservice was provided to the Wound Nurse regarding care plan implementation for pressure injury by the DON/designee by Oct 21, 2017. •□□□□□□□□ Care plans are reviewed and revised at least	10/21/2017

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	No care plan was present in regards to pressure area to left heel. During an interview, on 9/19/17 at 2:47 P.M., the Wound Nurse indicated a care plan should have been developed for Resident #70's heel wound.		quarterly and with significant changes in resident condition. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ Director of Nursing/designee will review care plans weekly x 4, monthly x 2, and quarterly x 2. •□□□□□□□□ Administrator/designee will review care plan report monthly for 90 days then quarterly thereafter or until a 95% threshold is met. •□□□□□□□□ Noncompliance with facility rules may result in re-education and/or disciplinary action. Compliance date: October 21, 2017	
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of			

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	care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to update care plan interventions for behaviors in 2 of 5 residents reviewed for behaviors. (Residents #69 and Resident #88) Findings include: 1. A clinical record review was conducted, on 9/19/2017 at 11:00 A.M.. for Resident #69 and indicated he was admitted on 11/6/15. His diagnoses included but were not limited to Parkinson's disease, and hallucinations.	F 0280	***F280** What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.* •□□□□□□□□ Resident #69 care plan was reviewed and revised as needed. •□□□□□□□□ Resident #88 care plan was reviewed and revised as needed ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ Residents residing in	10/21/2017

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	The quarterly MDS (Minimum Data Set) assessment, completed 7/29/17, indicated BIMS (Brief Interview for Mental Status) score a 99, unable to complete. The care plan for psychotropic drug use, no date, indicated he was taking a routine antipsychotic medication for the diagnoses for Parkinson's disease with hallucinations. An interdisciplinary note, dated 9/10/17, indicated Resident #69 was agitated and giving a certified nursing assistant a hard time with getting dressed, reaching for things in the air that is not there and batting at staff. The care plan for behaviors was reviewed and indicated it was not updated to include individualized interventions related to hallucinations. During an interview, on 9/19/2017 at 1:45 P.M., the Assistant Director of Nursing (ADON) indicated his behaviors were being tracked for reaching out and grabbing for things. During an interview on 9/19/2017 at 2:21 P.M., the Social Services manager indicated his antipsychotic medication was being used for hallucinations.		the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Social Service/designee will be responsible to update the care plan for residents with behaviors. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ An Inservice will be provided to IDT and nursing staff regarding care plan updates for resident's behaviors by the DON/designee by Oct 21, 2017. •□□□□□□□□ Care plans are reviewed and revised at least quarterly and with significant changes in resident condition. •□□□□□□□□ EMR (electronic medical record) Behavior tracking l with resident specific behaviors and interventions to utilize will be initiated after staff re- inservice by Oct 21, 2017. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ A Care Plan QA Tool will be utilized weekly x 4, monthly x 2, and quarterly x 2-to be reviewed by the DON/Designee. The Results of the audit tool will be provided to the QA Committee monthly for review and follow up. This will be completed monthly for 90 days then quarterly thereafter or until a 95% threshold of compliance is achieved •□□□□□□□□ Noncompliance with	

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	2. A clinical record review was conducted on 9/18/2017 at 12:14 P.M. for Resident #88 and indicated he was admitted on 1/30/17. His diagnoses included but not limited to other specific mental disorder due to known physical condition, post-traumatic stress disorder, personal history other mental and behavioral disorder, other recurrent depressive disorder. The care plan for behaviors was reviewed and indicated it was not updated to include individualized interventions related to being physically abusive and rejecting care. During an interview, on 9/18/17 at 4:22 P.M., Social Service Manager indicated Resident #88 was on risperdal for post traumatic stress disorder (PTSD) and the specific behaviors were while he was at home he was hitting his wife. She indicated he has not done any hitting since he had been admitted to the facility. A policy was provided by the ADON on 9/19/17 at 2:20 P.M., titled "Psychotropic Medications Policy", dated 3/2009, and indicated this was the current policy being used by the facility. The policy indicated "...4. Licensed nurses, along with Social Services, are responsible for collection and recording of baseline		facility rules may result in re-education and/or disciplinary action. Compliance date: October 21, 2017	

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	behavior data to define care plan goals for management of behaviors...." 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow care planned interventions related to medication monitoring for 1 of 29 residents reviewed for care plans (Resident #6). Findings include: A clinical record review was conducted, on 09/19/17 at 9:40 AM, for Resident #6 and indicated an admission date of 12/21/15. Her diagnoses included, but were not limited to: hypertension, depression, anxiety, hypothyroidism, GERD, glaucoma, heart failure, delusional disorders, and dementia without behavioral disturbance. Her medications included: Levothyroxine (hypothyroid), Lasix (heart failure),	F 0282	***F282*** It is the policy of Hamilton Grove to ensure residents receive services by a qualified persons/per care plan No residence were adversely affected by this alleged deficient practice ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** •□□□□□□□□ #6 care plan will be reviewed and revised as needed. AIMs test will be conducted by DON/designee and reviewed every six months or with a significant change. ***How other residents having the potential to be affected by the same alleged deficient practice***	10/21/2017

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	Cavediolol (hypertension), Ativan (anxiety), Cymbalta (depression), Zyprexa (delusional disorder). The most recent significant change MDS (Minimum Data Set) assessment, dated 06/16/17, indicated a BIMS (Brief Interview for Mental Status) score of 5, severe cognitive impairment. The assessment indicated antipsychotic, antianxeity, antidepressant and diuretic medications were used during the look back period. Care plans indicated a psychotropic medication use care plan with listed interventions to observe orientation, mood, and behaviors and to document findings in the record; it also listed an intervention to observe for side effects and to complete an AIMS assessment per protocol. The progress notes, TAR (Treatment Administration Record), and MAR (Medication Administration Record) documentation did not indicate monitoring for side effects or mood/behavior,and orientation had been completed. The AIMS assessment documentation indicated they were completed on the following dates: 06/20/16, 09/13/16,		***will be identified and what correction action (s) will be taken*** •□□□□□□□□ All residents with psychotropic medication usage residing in the facility have the potential to be affected by the alleged deficient practice. •□□□□□□□□ All residents receiving psychotropic medications or medications in a different drug classification prescribed to ameliorate behaviors such as Depakote will be given an AIMS (abnormal involuntary movement scale) to measure for EPS (extrapyramidal side effects). This will be completed by 10/21/2017 then every six months thereafter. •□□□□□□□□ Care plans are reviewed and revised at least quarterly and with significant changes in resident condition. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ A re-Inservice was provided to IDT and nursing staff regarding care plan updates for resident's behaviors by the DON/designee by Oct 21, 2017. •□□□□□□□□ Care plans are reviewed and revised at least quarterly and with significant changes in resident condition. •□□□□□□□□ EMR (electronic medical record) Behavior tracking with resident specific behaviors and interventions will	

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	12/12/16, 08/06/17, and 09/14/17. No documentation was available for the period between 12/12/16 and 08/06/17. During an interview, on 09/19/17 at 12:10 PM, the DON (Director of Nursing) indicated resident specific signs and symptoms for mood and behaviors would be listed in the assessments and given verbally during report. She was unable to provide what side effects to monitor for each type of psychotropic medication. During an interview, on 09/20/17 at 11:01 AM, the DON and MDS Coordinator both indicated no other assessments were available. A policy was provided by the ADON on 09/19/17 at 2:20 PM, titled "Psychotropic Medications Policy", dated 03/2009, and indicated this was the policy currently used by the facility. The policy indicated "...2. Licensed nurses shall document in the record and/or on a specialized form, the specific behavioral symptom(s) for which the drug was ordered...anti-depressant drugs...should be monitoring of drug side effects...." A policy was provided by the ADON on 09/21/17 at 2:35 PM, titled "Nursing Department Operations Manual", dated		be utilized after staff re-inservice by Oct 21, 2017. *How the corrective actions will be monitored to ensure the deficient practice will not recur.* •□□□□□□□□ A Care Plan QA Tool was developed to be utilized weekly x 4, monthly x 2, quarterly x 2. This will include information regarding the timeliness of AIMS testing. The Results of the audit tool will be provided to the QA Committee monthly for review and follow up. This will be done monthly for 90 days then quarterly thereafter or until a 95% threshold of compliance is achieved. •□□□□□□□□ Noncompliance with facility rules may result in re-education and/or disciplinary action. **Compliance date: October 21, 2017**	

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	04/19/04, and indicated this was the policy currently used by the facility. The policy indicated "...3. Reviews the use of the medication with the physician and interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and or the presence of any adverse effects of medication use. 4. AIMS will be performed on any resident on and antipsychotic on a quarterly basis changes will be reported to the physicians...." 3.1-35(g)(2)			
F 0314 SS=G Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, interview and observation, the facility failed to implement appropriate interventions to prevent the development or worsening of a pressure areas for 3 of 3 residents reviewed for pressure ulcers. This resulted in an unstagable pressure area to the left heel not present on admission (Resident #70), a Stage 2 pressure area on coccyx not present on admission (Resident #115) the worsening of Stage 2 pressure area to right gluteal fold to a Stage 4 with tunneling (Resident #17). Findings include: 1. The clinical record for Resident #70 was reviewed on 9/18/17 at 10:00 A.M. The diagnoses included, but were not limited to, diabetes, CVA (cerebrovascular accident), and hemiplegia. The admission MDS (Minimum Data Set) assessment, dated 7/5/17, indicated Resident #70 was admitted with no pressure areas, required extensive assist of 2 people for bed mobility, and was totally dependent for transfers.	F 0314	*F314* No residence were adversely affected by this alleged deficient practice *What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.* ·Resident #70 care plan has been developed and will be revised as needed. MD has been notified of resident condition. ·Resident #17 wound has been observed and staged appropriately. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** ·All residents with pressure injury or are assessed at high risk for such have the potential to be affected by the alleged deficient practice. ·Nursing re-inservice was conducted by the DON/designee on clean technique while	10/21/2017

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HAMILTON GROVE	31869 CHICAGO TR NEW CARLISLE, IN 46552

(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
	The Braden Scale, dated 6/28/17, indicated Resident #70 had a score of 12, at risk for pressure ulcer development. A care plan, dated 7/12/17, for risk of pressure ulcers related to impaired mobility (left side hemiplegia due to history of CVA) and incontinent of bowel/bladder included intervention, but were not limited to, use pressure reduction pad in wheelchair and mattress to bed to alleviate unwanted pressure to bony prominences and observe skin condition with routine care for red/open areas. The Interdisciplinary Notes, dated 7/11/17 at 4:04 P.M., indicated Resident #70's skin was free of pressure areas. The Interdisciplinary Notes, dated 8/2/17 at 7:54 P.M., indicated Resident #70 had a new pressure area on her left heel measuring 4.0 cm (centimeter) x 6.5 cm x 0 that was pale yellow with blue center. Area was found by CNA (certified nursing aide) when resident's shoe was removed. The Interdisciplinary Notes, dated 8/3/17, indicated Resident's husband felt pressure area was due to her kicking her legs and rubbing her heels against mattress at night.		changing dressings. Hand washing re-inservice was also provided by October 21, 2017. ·Residents at high risk for skin integrity compromise using the Braden scale will be assessed for low loss alternating air pressure mattresses placement to prevent the development of pressure areas. This will be done on admission or when a significant condition change is noted. · In addition, residents will receive a general purpose pressure reducing seat cushion. A therapy screen for a specialty seat cushion will be provided should a resident require one. proper seat cushion recommendations to prevent skin breakdown-on admission and when a significant condition change occurs. *What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.* ·A nursing Re- inservice was conducted by the DON/designee on clean technique while changing dressings. Hand washing re-inservice was also provided by October 21, 2017. ·A Skills validation tool will be developed to ensure nurses/QMA are competent for hand washing and dressing change procedures upon hire and as needed for identified issues. ·Licensed nurses will perform a	

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	The care plan was updated on 8/4/17 with intervention to apply shin splint. The Skin Evaluation Form, dated 8/4/17 at 4:24 P.M., indicated Resident #70 had pressure area to left heel at 4.0 cm x 6.5 cm x 0 cm that presented as yellow skin with small 0.3 cm blue area in center and 6.5 cm x 6.5 cm area was the yellow area that originated on 8/4/17. The treatment was to float heels at all times, apply bunny boots when in wheelchair. No updates were noted to the care plan in regards to floating heels or bunny boots. The Skin Evaluation Form, dated 8/9/17 at 10:08 A.M., indicated pressure area to left heel present was soft mushy skin with darkened areas under skin. Treatment was to float heels at all times, apply bunny boots when in wheelchair, and skin prep. No physician notification was available in regards to changes in wound description. No updates were noted to the care plan. The Skin Evaluation Form, dated 8/16/17 at 8:45 A.M., indicated Resident #70's left heel pressure area presented darkened mushy skin. Treatment remained float		weekly skin assessment and notify the wound nurse/MD/family for any issues. ·Resident's care plan for wounds will be developed/revised/updated as needed. ·Wound nurse will conduct weekly assessment of pressure injuries and document findings on skin condition form and include data on the QA weekly wound report for discrepancies to the IDT (interdisciplinary team) for review. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** ·Administrator/designee will review the wound report weekly for wound management issues any changes will be addressed immediately with nursing and therapy. These reports will be submitted to the QA for further review and evaluation monthly for 90 days then quarterly thereafter or until a 95% threshold for compliance is achieved. **Compliance date: October 21, 2017**	

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	heels at all times, bunny boots when up in wheelchair, skin prep. The Nursing Home Documentation Form signed by the physician, dated 8/18/17, indicated Resident #70 had a large closed blister to the left heel and assessment and plan was to pad area for decreased in friction, continue skin prep and monitor with wound care. No updates noted to care plan. The Skin Evaluation Form, dated 8/23/17, indicated the wound to the left heel presented with dark mushy skin with open areas to blister. The Interdisciplinary Notes, dated 8/23/17, indicated area to left heel had "opened up but skin was still intact, area measured 4.5 cm x 6 cm", no depth noted. Area was dark and was very mushy, new treatment ordered for hydrogel dressing and foam, wrap in kerlex. The Skin Evaluation Form, dated 8/30/17, indicated pressure area to left heel measured 4.5 cm x 6.0 cm x 0 depth, tissue type to wound base was slough (necrotic tissue) with purulent drainage, with mild odor.			

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	The Interdisciplinary Notes, dated 9/6/17, at 7:22 A.M., indicated the wound to the left heeled measured 5.5 cm x 6 cm, skin was peeling off heel, pink tissue with some dark spots towards the back of the heel with serosanguineous (bloody) drainage noted. No physician notification noted in regards to changes in the wound. No updates noted to the care plan. The Interdisciplinary Notes, dated 9/13/17 at 11:46 A.M., indicated area to left heel measured 5.2 cm x 6 cm, all the skin was off the area of the blister. There was a small back area to the center of the heel. The heel was mushy, surrounding tissue was pink. There was a small amount of serosanguineous drainage noted. Resident used air mattress. The Nursing Home Documentation Form signed by her physician, dated 9/21/17, indicated left heel wound with eschar (dry necrotic tissue) noted to base of wound. New order for Santyl to wound with telfa and kerlix daily. During an interview, on 9/19/17 at 2:47 P.M., the Wound Nurse indicated the pressure area to left heel started on 8/4/17 as a blister type wound, considered a Stage 2 pressure area and the pressure			

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	area had progressed to a Stage 3 according to last assessment with a heel mushy with skin still intact and a darkened area to center of wound with a little drainage serosanguineous. He indicated wound should be classified as unstageable pressure area due to the necrotic tissue that covered the center of the wound base and the current dressing was not appropriate for the type of tissue that was present in the wound. He indicated the outside facility wound nurse was following the wound progression and he had not notified the physician to visualize the wound. He indicated a care plan should have been developed and updated with changes in wound, treatments and preventative interventions and he was note aware of the pressure area to the heel was originally noted on 8/2/17 and that the physician should have been notified at that time and treatment orders should have been obtained. During an observation, on 9/19/17 at 3:15 P.M., Resident #70's pressure area to left heel was observed with RN #2. The wound presented 30% present granulation tissue and 70% dry eschar to center of wound. The RN #2 indicated the wound measured 6.4 cm x 5.2 cm x 0.2 cm. No air mattress was observed on the bed.			

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	During an interview, on 9/20/17 at 12:29 P.M., the ADON (Assistant Director of Nursing) indicated there was not an air mattress on bed as stated in note form 9/13/17 and care plans should have been developed for pressure areas and updates with changes to wound, treatments, and preventive interventions. She indicated the physician should have been notified with wound changes and family education should have been document and completed. During an interview, on 9/21/17 at 10:00 A.M., the physician for Resident #70 indicated she had not assessed the wound since her last visit on 8/18/17 and was unaware of any changes in the wound. On 9/21/17 at 10:13 A.M., Resident #70's physician was observed to assess the pressure area to the left heel. The physician indicated, at this time, the wound had eschar at the base and had worsened since last time she looked at it. She indicated to the resident's husband the dressing currently being used was for healthy tissue and the order would be changed that day. 2. A clinical record review was conducted on 9/18/2017 at 4:10 P.M. for Resident #17 and indicated resident was admitted on 1/21/15. Her diagnoses included but were not limited to type 2			

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	diabetes with diabetic polyneuropathy, depressive disorder, anxiety disorder, pressure ulcer, rheumatoid arthritis, hyperlipidemia, esophageal reflux, congestive heart failure, neuromuscular dysfunction. Resident #17 was admitted with a stage 1 and a stage 2 pressure ulcer to her buttocks and coccyx. A quarterly Minimum Data Set (MDS) assessment, dated 7/2/17, indicated the Brief Interview for Mental Status (BIMS) score, was 15, cognitively intact, and the resident currently had a stage 4 pressure ulcer. The care plan, undated, indicated Resident #17 had a stage 4 pressure ulcer to right buttock and the goal of the care plan indicated the unstageable pressure ulcer would decrease in size. During an observation, on 9/18/17 at 4:15 P.M., Resident #17 was in bed laying on her back. On 9/19/17 at 8:45 A.M., review of Resident #17's clinical record indicated the following: An assessment titled, Skin Evaluation Form, dated 3/15/17, indicated the wound to right buttock was a stage 4, it measured 2.6 cm long x 2.0 cm wide by 0.5 cm deep and no undermining or sinus			

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	tract was indicated. The assessment, dated 3/29/17, indicated the wound was unstageable, it measured 4.2 cm long x 1.2 cm wide x 0.5 cm deep and had slough with no sinus tract or undermining. The assessment, dated 4/12/17, indicated the wound was a stage 3 and measured 4.5 cm long x 2.2 cm wide x 0.4 cm deep with no sinus tract or undermining. The assessment, dated 4/26/17, indicated the wound was a stage 2 measured 4.6 cm long x 1.7 cm wide x 0.7 cm deep and no undermining or sinus tract but had maceration. No further assessments after 4/26/17 indicated the wound had been staged with weekly assessments and the last documented staging was a stage 2. Interdisciplinary notes, dated 7/30/17 at 2:03 P.M., indicated the wound was deeper and there was foul smelling drainage and black slough tissue and the wound had recently started to decline. Interdisciplinary notes, dated 8/23/17 at 9:47 A.M., indicated the wound bed had 80% slough and 20% necrotic tissue and a moderate amount of drainage with a			

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	slight odor, wound edges were slightly macerated. The resident indicated she could feel slightly more pain to the wound than before. Interdisciplinary notes, dated 9/4/17 at 12:39 A.M., indicated on 9/3/17 at 7:00 P.M., a new order was obtained for flagyl sprinkles to the wound bed. Interdisciplinary notes, dated 9/5/17 at 4:32 P.M., indicated the wound had very heavy serosanguinous (thin, watery bloody drainage) exudate that soaked her skirt. Interdisciplinary notes, dated 9/6/17 at 2:18 P.M., indicated keflex 500 mg was to start for 7 days. Hospice Nursing visit note, dated 9/6/17 at 8:25 P.M., indicated the resident was currently on keflex for wound infection. A wound assessment, dated 9/13/17, indicated the wound was assessed by the wound nurse, it measured 5 cm long x 3.0 cm wide x 4 cm deep was macerated and had undermining and a sinus tract at 12 o'clock measuring 7 cm deep and no staging of the wound was documented. During an observation, on 9/19/2017 at 10:20 A.M., the resident was in bed			

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	laying on her back. On 9/20/17 at 9:15 A.M., RN #2 was observed providing a dressing change to the pressure ulcer on Resident #17's right buttock. She was observed to wash her hands, leave the room to get a different size box of gloves. She returned to the room and covered the over the bed table with a towel and laid out her dressing supplies. She moved the over the bed table around to the other side of the resident's bed and adjusted the track lights over the bed by moving the track lighting around, and then adjusted the bed height. She put on gloves and removed the dressing and washed her hands for 7 seconds and applied new gloves and then moved the table around again and opened gauze pads and squeezing lidocaine jelly onto the inside of an open package. She wet all of the gauze pads with wound cleanser and cleansed the wound using a clean gauze each time. She measured the wound and the wound measured 5.4 cm long x 2.9 cm wide x 5 cm deep at the 6 o'clock area on the wound and indicated that was the area that was tunneling. The hospice nurse, who was in the room, indicated the wound nurse had indicated the tunneling was at 12 o'clock. RN #2 changed her gloves without cleansing her hands and applied lidocaine jelly around the outside			

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	of the wound and then pushed calcium alginate dressing into the wound with her gloved finger. She removed her gloves put on new gloves without cleansing her hands and applied a fibersorb dressing. Observation of the wound showed the wound to be beefy red with granulation tissue (new tissue that forms on the healing surface of a wound) to the visible part of the wound at the surface and edges with maceration (softening and whitening of the skin that is kept moist) around the wound edge. Unable to visually see the base (bottom) of the wound. During an interview, on 9/20/2017 at 10:30 A.M., the Assistant Director of Nursing (ADON) indicated that wounds are not to be downstaged and if the stage of the wound had not changed the staging would not have to be documented weekly. During an interview, on 9/20/2017 at 11:16 A.M., MDS LPN indicated that Resident #17 has a stage 4 pressure ulcer to her right buttock. She indicated the staging was to be done on the Skin Evaluation form weekly. 3. A clinical record review was conducted, on 09/19/17 at 10:07 AM, for Resident #115 and indicated an			

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	admission date of 08/14/17. His diagnoses included, but were not limited to: heart failure, hypertension, diabetes, hyperlipidemia, depression, asthma, pain, and weakness. The MDS (Minimum Data Set) assessment, dated 08/21/17, indicated a BIMS (Brief Interview for Mental Status) score of 13, cognitively intact. The assessment indicated only skin tears were present upon admission, no pressure areas were documented. During an interview, on 09/19/17 at 3:10 PM, LPN #7 (Licensed Practical Nurse) indicated the pressure area to Resident #115's coccyx was identified on 08/24/17 and he first assessed it on 08/30/17. The wound documentation only indicated measurements on 08/30/17, which were as follows: 3.0cm x 2.0cm x 1.1cm. The wound was listed as a stage 2 pressure area with granulation tissue. No wound assessment information was available for the onset date of 08/24/17 and no further documentation was available. On 9/19/17 at 2:32 P.M., the DON provided the Skin Condition and Pressure Ulcer Assessment Policy, no dates, and indicated the policy was the one currently being used by the facility. The policy indicated at the earliest sign of a pressure			

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	or other tyrp of ulcer, or problems, the resident's legal representative, and attending physician would be notified. Weekly assessment of skin problems, would occur until areas were healed and physician and responsible party would be informed of progress. The nurse was responsible for notifying the physician of any suspected infection in the wound, lack of response to treatment and what nursing and dietary interventions had been initiated. The resident's care plan would be revised as appropriate, to reflect specific skin problem and care. Response to the treatment would be documented in the nursing progress notes. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0329 SS=E Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or			

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	(2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on interview and record review, the facility failed to ensure antipsychotic medications had appropriate indications for use, failed to properly monitor and document individualized behaviors and medication specific side effects, and failed to initiate care plans or perform	F 0329	***F329*** *THERE IS NO RESIDENT IDENTIFIED AS # 89 ON THE RESIDENT LIST* *No residents were adversely affected by this alleged deficient practice* ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.***	10/21/2017

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	GDR (Gradual Dose Reductions) for psychoactive medications for 4 of 5 residents reviewed for unnecessary medications (Residents #6, #69, #86, & #89). Findings Include: 1. A clinical record review was conducted, on 09/19/17 at 9:40 AM, for Resident #6 and indicated an admission date of 12/21/15. Her diagnoses included, but were not limited to: hypertension, depression, anxiety, hypothyroidism, GERD, glaucoma, heart failure, delusional disorders, and dementia without behavioral disturbance. Her medications included: Levothyroxine (hypothyroid), Lasix (heart failure), Cavediolol (hypertension), Ativan (anxiety), Cymbalta (depression), and Zyprexa (delusional disorder). The most recent significant change MDS (Minimum Data Set) assessment, dated 06/16/17, indicated a BIMS (Brief Interview for Mental Status) score of 5, severe cognitive impairment. The assessment indicated antipsychotic, antianxiety, antidepressant and diuretic medications were used during the look back period. Care plans indicated a psychotropic		It is Hamilton Grove's policy to ensure drug regimen is free from unnecessary drugs. No residence were adversely by this alleged deficient practice. ·Resident #6 Medication regimen was reviewed for gradual dose reduction of psychotropic medication. ·Resident #69. AIMs test will be conducted by DON/designee and reviewed every six months or with a significant change. ·Resident #86 AIMs test will be conducted by DON/designee and reviewed every six months or with a significant change. ·Resident#89 (we think it should be #88 per identifier list) AIMs test will be conducted by DON/designee and reviewed every six months or with a significant change. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** ·Residents on psychotropic medication have the potential to be affected by the alleged deficient practice. · An EMR (electronic medical record) behavior monitor log with resident specific behaviors and interventions to utilize every shift	

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	medication use care plan with listed interventions to observe orientation, mood, and behaviors and to document findings in the record; it also listed an intervention to observe for side effects, but did not provide specific side effects to the different types of psychotropic medications (antidepressants, antianxiety, and antipsychotic medications). The behavior care plan listed interventions to redirect behavior to something positive and to notify physician of unusual cognitive/mood/behavioral functioning, no baseline or positive activities were provided. The mood care plan listed an intervention to report acute, unusual depression symptoms to the physician and to refocus to positive behavior, no baseline or positive activities were provided. The progress notes, TAR (Treatment Administration Record), and MAR (Medication Administration Record) documentation did not indicate monitoring for side effects or mood/behavior and orientation had been completed. The AIMS assessment documentation indicated they were completed on the following dates: 06/20/16, 09/13/16, 12/12/16, 08/06/17, and 09/14/17. No documentation was available for the		and staff re-inserviced by Oct 21, 2017. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** ·The Interdisciplinary Team (IDT) will review residents with behaviors, daily (Mon through Fri) at the clinical meeting to ensure residents with behaviors are monitored. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** ·The Administrator/designee will review at least 5 residents/monthly receiving psychotropic medications to ensure medication side effects, behaviors and gradual dose reductions have been completed. ·Results of the audit tool will be provided to the QA Committee monthly for review and follow up. This will be done monthly for 90 days then quarterly thereafter or until a 95% threshold of compliance is achieved. **Compliance date: October 21, 2017**	

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	period between 12/12/16 and 08/06/17. During an interview, on 09/19/17 at 12:10 PM, the DON (Director of Nursing) indicated resident specific signs and symptoms for mood and behaviors would be listed in the assessments and given verbally during report. She was unable to provide what side effects to monitor for each type of psychotropic medication. During an interview, on 09/20/17 at 11:01 AM, the DON and MDS Coordinator both indicated no other AIMS assessments were available.			
F 0332 SS=D Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to administer medications per policy and manufactures guidelines. There were 27 opportunities with 9 errors resulting in a 33.3% medications error rate. The errors involved 3 residents (Resident #19, Resident #75 and Resident #45). Findings include:	F 0332	***F332*** It is Hamilton Grove's policy and practice to ensure residents are free from medication error rates of 5% or more. No residence were adversely affected by this alleged deficient practice	10/21/2017

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	1. During an observation, on 9/20/17 at 8:14 A.M., RN (Registered Nurse) #3 was observed administering Symibort inhaler to Resident #75. She allowed resident to administer 2 puff of the inhaler to himself. She did not instruct resident to wait between puffs or to rinse mouth after use. The directions on the pharmacy label indicated to inhale 2 puffs by mouth every 12 hours to prevent breathing problems, rinse mouth after use. 2. During an observation, on 9/20/17 at 8:20 A.M., RN #3 was observed administering digoxin 0.125 mcg (micrograms) to Resident #19 along with amlodipine 5 mg (milligrams), a Centrum tablet, eliquis 2.5 mg and metoprolol 200 mg. RN #2 was not observed to assess Resident #19 pulse prior to administration of digoxin. During an interview, on 9/20/17 at 8:30 A.M., RN #3 indicated pulse was not documented for digoxin because on new medications require assessments not maintenance medications that residents have been on for awhile. The nursing considerations for administering digoxin, from Lippencott Nursing 2006 Drug Handbook, indicated		***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** Resident #19 apical radial pulse is checked and documented prior to administration of digoxin. Resident #75 is instructed to rinse mouth after use of inhaler and to wait between inhalations of inhaler. Resident #45 gastrostomy tube is flushed with H2O per policy before and after individual medication administration. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** ·All residents who receive medications have the potential to be affected by the alleged deficient practice. ·Nursing Re- inservice will be conducted by the Pharmacist/designee, including RN #3, on medication administration procedures by 10/21/17. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** ·DON/designee will develop a	

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	before giving drug, take apical-radial pulse for one minute. Record and notify prescribed of significant changes. Excessive slowing of the pulse rate (60 beats per minute or less) may indicate a sign of digitalis toxicity. 3. During an observation, on 9/20/17 at 9:32 A.M., RN #3 was observed administering Protonix 40 mg packet, bumetamide 1 mg tab (crushed), Lexapro 10 mg tab (crushed), Lisinopril 10 mg (crushed), probiotic tab (crushed), loperamide capsule (opened and emptied capsule into medicine cup), and acetaminophen 650 mg (crushed) into Resident #45's G-tube. RN #3 placed all medications onto the same medicine cup and proceeded into Resident #45's room. She turned off feeding pump that was running at 84 ml/hr (milliliters per hour) with Promote feeding, checked placement of G-tube and checked for residual, she was observed to flush G-tube with 20 ml (milliliters of water), added water to medicine up that contained all the mixed medications, and poured mixture into G-tube. She had to repeat this process a three times to ensure all medication was removed from cup and administered. She then flushed the G-tube with remaining 15 ml of water and turned the feeding pump back on to 84 cc/hr with Promote infusing.		Skills Validation tool to ensure nurses/QMA are competent to pass medication upon hire and as needed for identified issues. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** ·Administrator/designee will conduct a medication administration audit with at leasta1 nurse or QMA monthly x 6 to ensure administration procedures are adhered to by DON/designee. This will be done monthly for 90 days then quarterly thereafter or until a 95%threshold of compliance is achieved. **Compliance date: October 21, 2017**	

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	During an interview, on 9/20/17 at 9:42 A.M., RN #3 indicated she was not aware of how much flush to give prior to medication administration and after last medication was administered. The Patient Instructions on the Protonix package, indicated Protonix granules should be taken approximately 30 minutes before a meal. During an interview, on 9/20/17 at 9:10 A.M., the ADON (Assistant Director of Nursing) indicated the wait time between inhaler puffs was 1 minute and a resident should rinse mouth after use of Symbicort inhalers. She indicated that the pulse should be taken and documented prior to administering digoxin She indicated medications administered through a G-tube should be given one at a time, and flushed according to policy. On 9/20/17 at 11:00 A.M., the ADON provided the Naso-Gastric Tube Feedings policy, no date, and indicated the policy was the one currently being used by the facility. The policy indicated each medication was to be given separately, and flush tube after each medication with 5 ml or more water as needed to clear tube.			

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	3.1-48(c)(1)			
F 0356 SS=C Bldg. 00	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this			

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	section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post nurse staffing information that included actual worked hours of licensed and unlicensed staff that was providing resident care. Finding includes: During an observation, on 9/18/17 at 9:30 A.M., the posting for nurse staffing was located on the wall by the Health Care Entrance by the therapy department, that included the number of nurses and certified nurse aides scheduled to work on 9/18/17. It did not included the scheduled hours or the did not have a actual hours worked on previous shifts.	F 0356	***F356*** It is the policy of Hamilton Grove to post the daily nurse staffing data in a conspicuous common area. No residence were adversely affected by this alleged deficient practice ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice.*** *It is the policy of Hamilton Grove to ensure nursing staff information is posted in a timely manner.*	10/21/2017

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	During an interview, on 9/18/17 at 9:45 A.M., the ADON (Assistant Director of Nursing) indicated the actual hours worked and the scheduled hours were not posted, only the number of each discipline that was scheduled to work. She indicated she was not aware that the posting needed to include that hours. On 9/18/17 at 10:00 A.M., the ADON provided the Staffing Policy, and indicated the policy was the one currently being used by the facility. The policy indicated a public notice in print and size large enough to be easily areas will be posted daily regarding the number of nursing staff on duty for each shift in the twenty-four hour period. Posting will include at least the number of staff on duty who are licensed nurses, certified nursing assistants, and nursing management whose responsibilities directly affect residents.		·No residents were identified or adversely affected by this alleged deficient practice. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** ·All residents residing in the facility have the potential to be affected by the alleged deficient practices. ·The nursing posted hours form has been revised to include actual hours worked. Nursing hours are posted daily. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** ·The DON/designee is responsible for posting the "nursing hours form" in a conspicuous area daily to ensure compliance. This will include information regarding the previous day's staffing information as well as current projected staffing allocations. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** ·Administrator/designee will observe posting to ensure daily	

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			hours are added. These daily postings will be submitted to the QA committee for further review and evaluation every 30 days for the first 90 days then quarterly thereafter or until a 95% threshold compliance is achieved. **Compliance date: October 21, 2017**	
F 0364 SS=D Bldg. 00	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; Based on interview and observation, the facility failed to ensure to maintain the proper temperature on 2 of 2 test trays. Findings Include: Observations on 9/14/17 at 12:42 P.M., included the following: The last tray on the food cart in the East dining room was tested for proper temperature. The tray had 2 glasses of milk and mixed vegetables. The temperature of the first glass was 42.3	F 0364	**F364** No residence were adversely affected by this alleged deficient practice It is the policy and practice of Hamilton Grove serve food prepared by methods that conserve nutritive value, flavor and appearance. ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice?*** •□□□□□□□□ Sufficient time has elapsed to preclude correction of	10/21/2017

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	degrees and the second glass was 43 degrees. The Certified Dietary Manager (CDM) indicated it should be 41 degrees or under. The temperature of the mixed vegetables was 107 degrees and the CDM indicated it should be 140 degrees. Observations on 9/18/17 at 1:00 P.M., included the following: Test tray on the food cart in the East dining room was tested for proper temperature. The tray was the last one on the cart to be removed. The tray had a glass of milk, lemon meringue pie, baked potato, a slice of pork with gravy and california blend vegetables. The temperature of the milk was 43 degrees and the pork slice was 135 degrees. The Assistant Food Service manager indicated the milk should be between 40 and 41 degrees and the pork slice should be 140 degrees. A policy was provided by the Assistant Director of Nursing on 9/18/17 at 9:20 A.M., titled, "...Assistance with Meals", revised September 2013, and indicated the policy was the one currently being used by the facility. The policy indicated "...hot foods shall be held at a temperature of 136 degrees or above until served. Cold foods shall be held at 40 degrees of below until served...."		an alleged past deficiency. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ All residents in the healthcare facility have the potential to be affected by the alleged deficient practice. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ A re-inservice was provided to current dietary staff regarding checking food temperatures by Dietary Manager/designee by October 21, 2017. •□□□□□□□□ Food temperature is taken 30 minutes before serving and when food is put into steam table. •□□□□□□□□ Dietary manager/designee will be responsible to take temperature and record on food Temperature log to ensure temperature is at the appropriate level prior to serving. •□□□□□□□□ In addition the dietary manager/ designee will sample A “test tray” from a different meal will be taken three times a week and recorded on a separate log form. ***How the corrective actions will be monitored to ensure the deficient practice will not recur***	

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	3.1-21(a)(2)		•□□□□□□□□ Dietary manager/designee will submit a summary report of food temperatures will be provided to the Quality Assurance committee for review and follow up. •□□□□□□□□ Noncompliance with facility policy may result in re-education and/or disciplinary action. Compliance date: October 21, 2017	
F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and			

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	sanitary storage, handling, and consumption. Based on observation and interview the facility failed to ensure meals were served under sanitary conditions in regards to serving food with thumb on the eating surface of the plates and hand over the top of dishes and cups during meal service in 2 of 3 dining rooms observed (Center and West) and food storage for 1of 1 kitchens observed. Findings include: 1. During an initial tour with the certified dietary manager (CDM) on, 9/14/17 from 11:30 A.M. to 12:20 P.M., the following were noted: On the dry storage shelves, food items opened with no use by date or expiration date were: sage seasoning opened with no open date, mild chili powder opened 3/30/16, ground thyme open 2/2002, mesquite herb fajita seasoning opened 8/25/05, western barbeque spice opened 9/13/11, curry powder opened 1/21/16, herbs of provence opened 6/29/12, dill weed opened with no open date, onion powder opened with no open date, spanish paprika opened 4/20/15, whole celery seed opened 2/23/15, garlic herb seasoning opened with no open date, decorative colored sprinkles opened	F 0371	**F371** **No residents were adversely affected by this alleged deficient practice.** By way of clarification: leading experts such as McCormick the leading manufacturer of spices and herbs indicate the shelf life for (1) ground spices is 2-3 years; (2)Whole spices is 3-4 years (3) seasoning blends 1-2 years; (4) herbs 1-3 years; and (5) extracts 4 years –except pure vanilla which lasts indefinitely. They also indicate that spices and herbs do not “spoil” but lose their potency over time. No one is ever at risk to get sick from expired spices or herbs-according to the currents of literature. This may be the reason Manufacturers do not provide an expiration date on spices and herbs because they never really “expire” they only lose intensity of flavor. Nevertheless, in a spirit of cooperation with this new interpretation for spice and herb expiration dates by the Indiana State Department of Health conveyed through the survey process, Hamilton Grove proposes the following remedies: ***What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice?*** No residents were adversely affected by this alleged practice.	10/21/2017

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	8/6/17, imitation vanilla opened 6/1/17, molasses opened with no open date, dried onions opened 7/12/17, corn syrup opened 11/3/14, Drakes crispy frymix opened 9/3/17. CDM was unaware of the expiration dates or shelf life of the food items. In the refrigerator there were bacon opened 9/14/17 with no use by date, three containers of Dannon yogurt expired 9/8/17, swiss cheese with no use by date and cheddar cheese with no use by date, pulled pork dated 9/13/17 with no use by date. CDM indicated once opened in the refrigerator items were good for three days. In the freezer there were chopped patties dated 9/13/17 with no use by date, corn on the cob dated 9/2/17 with no use by date, ham loaf dated 9/7/17 with no use by dates, garlic bread opened 9/12/17 with use by date. CDM indicates anything frozen is good for six months. Bins with oatmeal dated 7/16/17 with no use by date or expiration date and bread crumbs dated 8/3/17 with no use by date. CDM unsure how long it was good for. On the bread rack there were 23 loaves of bread with no use by dates. CDM		However, all identified dated spices and herbs were removed from the shelves. All identified outdated open food containers were removed from the refrigerator/freezer. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** •□□□□□□□□ All residents residing in the facility have the potential to be affected by the alleged deficient practice. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** •□□□□□□□□ A re-inservice was provided to current dietary staff regarding dating and labeling of food by Dietary Manager/designee by October 21, 2017. •□□□□□□□□ A list of expiration dates has been created for staff to follow to ensure food is labeled and dated when open. •□□□□□□□□ A re-inservice was provided by the DON/designee on meal service procedures related to infection control and hand washing by Oct 21, 2017. •□□□□□□□□ Noncompliance with facility rules may result in re-education and/or disciplinary action. •□□□□□□□□ Dietary	

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	155672	A. BUILDING 00 B. WING	09/21/2017

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	indicated she was not sure how long the bread was good for. There were a package of hamburger buns opened with no opened date or use by date and a package of hot dog buns opened with no opened date or use by date. CDM indicated once they were opened use by three days. During second tour with the certified dietary manager on, 9/18/17 from 10:38 A.M. to 11:15 A.M. Gravy sauce packets with no use by date or expiration date, cocoa powder opened 1/21/17 with no use by date or expiration date, no use by dates on soybean oil, buttermilk ranch dressing, heavy duty mayonnaise, blueberry jello, cherry gelatin, barbeque packets and tartar sauce packets. A policy was requested but one was not provided. 2. During dining observation on 9/14/17 at 12:27 P.M., in the Center dining room, RN #3 was observed to grab the top of the dessert dish, a coffee cup, a dish of ice cream and a glass of cranberry juice when serving them to a resident. During dining observation on 9/17/17 at 12:18 P.M., in the West dining room, certified nursing assistant (CNA) #12		Manager/designee will be responsible for dietary staff compliance in the kitchen area. •□□□□□□□□ Any deficiencies observed will be immediately corrected •□□□□□□□□ DON/designee will be responsible to staff compliance on the units for sanitation purposes on the nursing units. •□□□□□□□□ A Kitchen Sanitation checklist will be completed weekly ongoing by the Dietary Manager/designee. Results of the checklist will be provided to the QA Committee monthly for review and follow up. •□□□□□□□□ Noncompliance with facility policy may result in re-education and/or disciplinary action. •□□□□□□□□ DON/designee will monitor at least one unit daily via sanitation rounds check list noting compliance for infection control. The results of this monitoring system will be submitted to the Administration weekly. •□□□□□□□□ ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** •□□□□□□□□ Administrator/designee will review the weekly infection control rounds check list for compliance along with the kitchen sanitation checklist. The results of these respective QA forms will be submitted to the QA committee	

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	was observed to wash her hands for 12 seconds and observed placing her thumb on the eating surface of a dessert plate when serving a resident. During dining observation on 9/17/17 at 12:43 P.M., in the Center dining room, RN #3 was observed putting hand over the top of dessert dish when serving a resident and CNA #14 placing his thumb on the eating surface of a dessert plate when serving a resident. During a dining observation on 09/17/17, from 12:33 PM to 12:48 PM, CNA #12 was observed washing her hands for a period of 12 seconds. She was then observed serving trays and accessed a closet to take an item into a resident's room. After she exited the room she was observed doing a 3 second rinse under the running water, without soap. CNA #12 returned to serving trays and knocked to bottle of hand sanitizer to the floor; she retrieved it and placed in back on the table and returned to serving trays. She was observed answering the phone during serving, then returned to serving residents without performing hand hygiene. The ADON (Assistant Director of Nursing) was observed serving trays without washing hands. A policy was provided by the ADON (Assistant Director of Nursing) on		for further review and recommendations. This will be completed at least 5 days a week (one unit per day for five units total) for 90 days-quarterly thereafter or until a 95% compliance rate is achieved. •□□□□□□□□ Dietary sanitation checks will be completed weekly for 90 days-quarterly thereafter or until a 95% compliance rate is achieved. Compliance date: October 21, 2017	

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	09/19/17 at 10:35 AM, titled "Handwashing/Hand Hygiene", dated 08/2015, and indicated this was the policy currently used by the facility. The policy indicated "...7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...l. After contact with with objects (e.g. medical equipment) in the immediate vicinity of the resident;...o. Before and after assisting a resident with meals...Washing Hands 1. vigorously lather hands...for a minimum of 20 seconds...Using Alcohol-Based Hand Rubs 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until they are dry...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT			

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Bldg. 00	SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure dressing changes were free from potential contamination for 2 of 2 residents observed for wound dressing changes. (Resident #70 and Resident #17) Findings include: 1. During an observation, on 9/19/17 at 3:15 P.M., RN #2 entered Resident #70's room, washed her hands in bathroom and placed on gloves. She then moved	F 0441	**F441** It is the policy of Hamilton Grove to prevent the spread of infections. No residence were adversely affected by this alleged deficient practice **What corrective action will be accomplished for those residents found to be affected by the alleged**	10/21/2017

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	bedside table to end of bed using her gloved hands. CNA (certified nursing assistant) #13 held up resident's left leg. RN #2 removed the dressing from left heel. She then removed gloves and no handwashing noted, she applied another pair. She sprayed wound cleanser on gauze pad and wiped wound with guaze pad. With same gloves and no handwashing noted, she proceeded to measure the wound with outside packet of cotton tip q-tips packet and then applied hydrogel dressing, covered with foam, and added kerlix. 2. On 9/20/17 at 9:15 A.M., RN #2 was observed providing a dressing change to the pressure ulcer on Resident #17's right buttock. She was observed to wash her hands, leave the room to get a different size box of gloves, she returned to the room and covered the over the bed table with a towel and laid out her dressing supplies. She moved the over the bed table around to the other side of the resident's bed and adjusted the track lights over the bed by moving the track lighting around, and then adjusted the bed height. She put on gloves and removed the dressing and washed her hands for 7 seconds and applied new gloves and then moved the table around again and opened gauze pads and squeezing lidocaine jelly onto the inside of an open package. She wet all of the		**deficient practice.** ·Resident #70 dressing change is completed with clean technique. ·Resident #17 dressing change is completed with clean technique. ***How other residents having the potential to be affected by the same alleged deficient practice will be identified and what correction action (s) will be taken*** ·All residents with dressing changes have the potential to be affected by the alleged deficient practice. ·Nursing re- inservice was conducted by the DON/designee on clean technique while changing dressings. Hand washing re-inservice was also provided by October 21, 2017. ***What measures will be put into place or what systematic changes will be made to ensure the alleged deficient practice will recur.*** ·DON/designee will develop and implement a skills validation tool to ensure nurses are competent for hand washing and dressing change procedures upon hire and as needed for identified issues. ***How the corrective actions will be***	

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	gauze pads with wound cleanser and cleansed the wound using a clean gauze each time. She measured the wound and the wound measured 5.4 cm long x 2.9 cm wide x 5 cm deep at the 6 o'clock area on the wound and indicated that was the area that was tunneling. The hospice nurse, who was in the room, indicated the wound nurse had indicated the tunneling was at 12 o'clock. RN #2 changed her gloves without cleansing her hands and applied lidocaine jelly around the outside of the wound and then pushed calcium alginate dressing into the wound with her gloved finger. She removed her gloves put on new gloves without cleansing her hands and applied a fibersorb dressing. During an interview on 9/19/17 at 8:45 A.M., the ADON indicated staff should wash their hands for 30 seconds. During an interview on 9/20/2017 at 12:20 P.M., the ADON indicated a Q-tip should be used to pack a wound. A policy was provided by the ADON on 9/19/17 at 10:35 A.M., titled, "Handwashing/Hand Hygiene", revised 8/2015, and indicated the policy was the one currently being used by the facility. The policy indicated "...This facility considers hand hygiene the primary means to prevent the spread of infections.		***monitored to ensure the deficient practice will not recur.*** ·Administration/designee will review the skills validation tool at least weekly to ensure compliance. This will be done at least monthly for the first 90 days then quarterly thereafter or until a 95% threshold of compliance is achieved. ***Compliance date: October 21, 2017***	

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	Washing hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under moderate stream of water, at a comfortable temperature. 2. Rinse hands thoroughly under running water...." A policy was provided by the ADON on 9/20/17 at 11:17 A.M., titled, "Wound Care", revised 10/2010, and indicated the policy was the one currently being used by the facility. The policy indicated "...1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table... 2. Wash hands thoroughly. 3. Position resident. 4. Put on exam glove. Loosen tape and remove dressing. 5. ...wash and dry your hands thoroughly. 6. Put on gloves. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 12. Apply treatments as indicated. 13. Dress wound. 16. Remove disposable gloves discard into designated container. Wash and dry your hands thoroughly...." 3.1-18(l)			
F 0518 SS=C Bldg. 00	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS			

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	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on record review and interview, the facility failed to perform unannounced staff drills for emergency procedures (missing persons and tornados). Findings include: On 9/21/17 at 1:15 P.M., review of emergency drills indicated no drills documented for missing persons and tornados. During an interview on 9/21/2017 at 1:24 P.M., the Executive Director (ED) indicated they do not perform any drills other than fire drills. On 9/21/17 at 3:30 P.M., a policy was requested but one was not provided. 3.1-51(b)	F 0518	***F 518*** ***No residents were adversely affected by this alleged deficiency.*** ***What measures will be put into place or what systemic changes will be made to*** ***ensure that the deficient practice does not recur;*** Sufficient time has elapsed to preclude the correction of past alleged deficiencies. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents at the facility have the potential to be adversely affected by this deficient practice. The policy for Tornado	10/21/2017

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			preparedness was reviewed and amended to state rehearsal drills to be completed twice a year. The policy for missing person drills was reviewed and amended to stat rehearsal drill to be completed twice a year. A missing person rehearsal drill will be completed by October 21, 2017. A Tornado rehearsal drill will be completed by October, 21, 2017. ***What measures will be put into place or what systemic changes will be made to*** ***ensure that the deficient practice does not recur;*** Maintenance Director (MD)/designee will add these two drill to the fire drill ancillary maintenance log schedule to ensure compliance. This will be reviewed by the MD/designee on a monthly basis.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ***i.e., what quality assurance program will be put into place?*** The Administrator will review the maintenance log monthly to ensure compliance with the Tornado and Missing person Drill. Any deficiencies will be immediately corrected. The results of these reviews will be submitted to the QA meeting for further review and recommendations. This will be done every 30 days for 90 days then quarterly thereafter. **The date by which systemic changes will occur: O**ctober 21, 2017	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaints IN00234087,	R 0000	Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact or conclusion set forth in the statement of deficiencies. The plan of correction is being submitted in good faith by the facility because it is required by	

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	IN00239282 and IN00233484. Complaint IN00234087 - Unsubstantiated due to lack of evidence. Complaint IN00239282 - Substantiated. No deficiencies related to this allegation are cited. Complaint IN00233484 - Substantiated. No deficiencies related to this allegation are cited. Survey dates: September 14, 15, 16, 17, 18, 19, 20, & 21, 2017. Facility number: 000427 Provider number: 155672 AIM number: 100275150 Residential Census: 75 Hamilton Grove of New Carlisle was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-5 in regard to the Residential State Licensure Survey. Quality Review was completed on September 28, 2017.		law. The facility reserves the right to contest the statement of deficiencies.	