STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 W SR 46 ELLETTSVILLE, IN 47429

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F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey Dates: April 23, 24, 27, 28, 29, 30, May 1, and 4, 2015. Facility number: 000558 Provider number: 155523 AIM number: 100267550 Census bed type: SNF/NF: 77 Total: 77 Census payer type: Medicare: 13 Medicaid: 46 Other: 18 Total: 77 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000	---This plan of correction constitutes Richland Bean-Blossom Health Care Center's written allegation of compliance for the deficiencies cited in the annual survey conducted April 23, 2015 through May 4, 2015. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet state and federal requirements. Richland Bean-Blossom Health Care Center respectfully requests consideration of this Plan of Correction for paper compliance. Plan of Compliance Date: 6-3-15	
F 225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 ensure an allegation of resident mistreatment was immediately reported to the administrator of the facility as indicated by the facility's abuse policy for 1 of 4 resident interviewed for an allegation of mistreatment. (Resident	F 225	**F225** 1. As soon as the allegation was made known by the ISDH surveyors, Resident #2 was interviewed, RN #4 was suspended and an investigation was initiated. The allegation was reported to the ISDH. The	06/03/2015

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	#2) Findings include: Resident #2's clinical record was reviewed on 4/29/15 at 10:32 a.m. Diagnosis include, but were not limited to: bipolar disorder, depressive disorder, insomnia, and schizoaffective. The current Minimum Data Set assessment dated 2/12/15, indicated a Brief Interview for Mental Status score was an 11, indicating interviewable and mildly cognitively impaired. On 4/24/15 at 1:52 p.m., Resident #2 indicated RN #4 talks mean to him all the time. "I don't want her to care for me. I told the nurses. [Name RN #4] gives me a hard time about me having my pops [soda]." On 4/30/15 at 11:33 a.m., Resident #2 indicated staff told him [Name RN #4] was given a different assignment and not to take care of him anymore. Resident #2 indicated RN #4 was still providing care for him.. On 4/30/15 at 11:45 a.m., CNA (Certified Nursing Assistant) #5 indicated, Resident #2, "usually asks me who is coming on shift after I leave." CNA #5		Administrator was notified on 4-24-15 of the allegation. 2. A review of the current grievance and concern log for the last 30 days was completed by the Administrator on 5-22-15. Staff and Resident interviews completed as of 6-2-15 to determine that any allegations of abuse or mistreatment had been reported to the Administrator and other agencies as required. No further concerns identified. 3. All staff members were re-educated on the Abuse, Neglect and Misappropriation of Property Policy as of 6-2-15 that included but was not limited to notifying the Administrator immediately. The Director of Nursing was re-educated by the Administrator on 5-22-15 to the Abuse Policy which included but not limited to the expectation that the Administrator is notified immediately of any allegations of abuse or mistreatment. A posttest was administered to all staff to measure understanding of the material and concepts presented. Allegations of Abuse and Grievance/Concerns are reviewed in the Daily Stand Up Meeting with the Administrator and Interdisciplinary team. 4. Allegations of abuse and neglect will be audited by the Administrator by reviewing all Abuse	

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	indicated, Resident #2 told her awhile ago (not sure of date) he didn't want RN #4 to provide care for him. On 5/3/15 at 4:50 p.m., RN #3 indicated she had not heard of any problems or concerns from Resident #2 about RN #4, other than she won't let him have his pops (soda). RN #3 was not sure of how long ago it was when Resident #2 told her that concern. On 5/3/15 at 11:30 p.m., RN #4 indicated she wasn't aware Resident #2 did not want RN #4 to care for him. RN #4 indicated a month ago RN #4 removed self from the care of Resident #2. RN #4 had not provided care for him since March 2015. On 4/27/15, RN #4 was scheduled to work the 200 hall as a CNA. "I changed assignments with RN #5." RN #5 indicated she was not aware Resident #2 did not want RN #4 to provide care for him. On 4/24/15 at 2:45 p.m., the Administrator indicated, he was not aware of any allegation of mistreatment concerning Resident #2. On 4/23/15 at 11:55 a.m., the Director of Nursing (DON) provided "ABUSE,		Allegations and the Current Months Grievance and Concern Log weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months to determine that the Administrator was notified. The results of the audits will be submitted to the Administrator for review when completed and then further reviewed by the monthly Quality Assurance Committee for further recommendations. Any allegations of abuse or neglect will be reported and investigated per policy. 5. Date of compliance: 6-3-15	

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	NEGLECT, AND MISAPPROPRIATION OF PROPERTY" dated 8/8/13, and indicated the policy was the one currently used by the facility. The policy indicated, "...Training ...2. Each new employee will be informed of his or her responsibility immediately report any ... alleged violation ... Executive Director. ... Identification: ...2. The facility will report the allegation to the State Agency in accordance with state law.... Investigation: 1. The facility will conduct an internal investigation and report ...within five working days or the incident or according to state law.... 3. b. Identification and removal of the alleged person, ...5. The alleged perpetrator of abuse is suspended during the investigation process....9. During the investigation, ...Removal of the alleged abuser from the patient care setting.... Protection: ...2. All allegations involving staff will necessitate suspension pending investigation. ... Protection: 1. All residents will be protected from harm. 2. All allegations involving staff will necessitate suspension pending investigation. ...Reporting and Response: 1. Allegations will be reported to the Executive Director immediately. ... " 3.1-28(c)			

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F 226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of the facility's abuse policy and procedure in that an allegation of mistreatment was not immediately reported to the administrator for 1 of 4 residents reviewed for an allegation of mistreatment. (Resident #2) (RN #4) Findings include: Resident #2's clinical record was reviewed on 4/29/15 at 10:32 a.m. Diagnosis include, but were not limited to: bipolar disorder, depressive disorder, insomnia, and schizoaffective. The current Minimum Data Set assessment dated 2/12/15, indicated a Brief Interview for Mental Status score was an 11, indicating interviewable and mildly cognitively impaired. On 4/24/15 at 1:52 p.m., Resident #2 indicated RN #4 talks mean to him all the time. "I don't want her to care for me. I	F 226	**F226** 1. As soon as the allegation was made known by the ISDH surveyors, Resident #2 was interviewed, RN #4 was suspended and an investigation was initiated. The allegation was reported to the ISDH. The Administrator was notified on 4-24-15 of the allegation. 2. A review of the current grievance and concern log for the last 30 days was completed by the Administrator on 5-22-15. Staff and Resident interviews completed as of 6-2-15 to determine that any allegations of abuse or mistreatment had been reported to the Administrator and other agencies as required. No further concerns identified. 3. All staff members were re-educated on the Abuse, Neglect and Misappropriation of Property Policy as of 6-2-15 that included but was not limited to notifying the Administrator immediately. The	06/03/2015

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	told the nurses. [Name RN #4] gives me a hard time about me having my pops [soda]." On 4/30/15 at 11:33 a.m., Resident #2 indicated staff told him [Name RN #4] was given a different assignment and not to take care of him anymore. Resident #2 indicated RN #4 was still providing care for him.. On 4/30/15 at 11:45 a.m., CNA (Certified Nursing Assistant) #5 indicated, Resident #2, "usually asks me who is coming on shift after I leave." CNA #5 indicated, Resident #2 told her awhile ago (not sure of date) he didn't want RN #4 to provide care for him. On 5/3/15 at 4:50 p.m., RN #3 indicated she had not heard of any problems or concerns from Resident #2 about RN #4, other than she won't let him have his pops (soda). RN #3 was not sure of how long ago it was when Resident #2 told her that concern. On 5/3/15 at 11:30 p.m., RN #4 indicated she wasn't aware Resident #2 did not want RN #4 to care for him. RN #4 indicated a month ago RN #4 removed self from the care of Resident #2. RN #4 had not provided care for him since March 2015.		Director of Nursing was re-educated by the Administrator on 5-22-15 to the Abuse Policy which included but not limited to the expectation that the Administrator is notified immediately of any allegations of abuse or mistreatment. A posttest was administered to all staff to measure understanding of the material and concepts presented. Allegations of Abuse and Grievance/Concerns are reviewed in the Daily Stand Up Meeting with the Administrator and Interdisciplinary team. 4. Allegations of abuse and neglect will be audited by the Administrator by reviewing all Abuse Allegations and the Current Months Grievance and Concern Log weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months to determine that the Administrator was notified. The results of the audits will be submitted to the Administrator for review when completed and then further reviewed by the monthly Quality Assurance Committee for further recommendations. Any allegations of abuse or neglect will be reported and investigated per policy. 5. Date of compliance: 6-3-15	

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	On 4/27/15, RN #4 was scheduled to work the 200 hall as a CNA. "I changed assignments with RN #5." RN #5 indicated she was not aware Resident #2 did not want RN #4 to provide care for him. On 4/24/15 at 2:45 p.m., the Administrator indicated, he was not aware of any allegation of mistreatment concerning Resident #2. On 4/23/15 at 11:55 a.m., the Director of Nursing (DON) provided "ABUSE, NEGLECT, AND MISAPPROPRIATION OF PROPERTY" dated 8/8/13, and indicated the policy was the one currently used by the facility. The policy indicated, "...Training ...2. Each new employee will be informed of his or her responsibility immediately report any ... alleged violation ... Executive Director. ... Identification: ...2. The facility will report the allegation to the State Agency in accordance with state law.... Investigation: 1. The facility will conduct an internal investigation and report ...within five working days or the incident or according to state law.... 3. b. Identification and removal of the alleged person, ...5. The alleged perpetrator of abuse is suspended during the			

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	investigation process....9. During the investigation, ...Removal of the alleged abuser from the patient care setting.... Protection: ...2. All allegations involving staff will necessitate suspension pending investigation. ... Protection: 1. All residents will be protected from harm. 2. All allegations involving staff will necessitate suspension pending investigation. ...Reporting and Response: 1. Allegations will be reported to the Executive Director immediately. ... " 3.1-28(a)			
F 246 SS=G Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a resident could alter the temperature of his room for his comfort as the facility's resident rights policy indicated in that a metal bar was screwed into the control panel of the heating/air conditioning unit covering the thermostat and the resident	F 246	**F246** 1. The bar was removed from the temperature control on the heater in Resident #29's room on 4/29/2015 during the ISDH survey by the Maintenance Director. The resident voiced satisfaction to the Administrator that he could adjust	06/03/2015

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	could not change the temperature of his room which resulted in mental anguish due to the resident always being cold for 1 of 40 observed residents during Stage 1. (Resident #29). Findings include: On 4/27/2015 at 11:36 a.m., during the Stage 1 interview with Resident #29, he indicated he had difficulty with the temperature in the building in that he was always cold in his bedroom. Resident #29 became upset and indicated the facility had placed a metal bar across his room thermostat, because he used to much heat which forced his room mates out. Resident #29 could not recall the name of the person who ordered the metal bar, but indicated the current maintenance man put the metal bar in place 2 months ago. On 4/27/2015 at 11:36 a.m., an observation of Resident #29's thermostat revealed a metal bar screwed into the heating/air conditioning unit which prevented Resident #29 from adjusting his room's temperature by himself. The metal bar was placed at an angle which, if on a clock, would be approximately 10:00 p.m. to 5:00 p.m. The clinical record was reviewed for		the room temperature now and that he was comfortable on 4-29-15 with no emotional or physical distress noted. 2. A room-to-room search was conducted on 5/17/2015 of all residents, and HVAC units in resident rooms to look for any resident right concerns including devices that limit residents ability to adjust the temperature by the Director of Nursing and Maintenance Director. No other concerns identified. 3. All staff were re-educated to Resident Rights and the expectation of immediately reporting any violations to the Administrator or Director of Nursing as of 6-2-15 with a reference to the right of the resident to adjust the room temperature to maintain comfort. The Maintenance Director was re-educated to Resident Rights that included the residents right to adjust the room temperature to maintain comfort by the Administrator on 5-22-15. 4. Resident Rights audits will be completed by the Administrator/Social Services Director or designee by interviewing 5 residents and reviewing the Grievance and Concern Log weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months to	

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	Resident #29 on 4/30/2015 at 11:05 a.m. Diagnoses included, but were not limited to depression and dementia. The quarterly MDS (Minimum Data Set) assessment, completed on 4/6/2015, indicated a Brief Interview for Mental Status (BIMS) score of 9 (when 8-15 was interviewable and cognitively intact), and assessed Resident #29's functional status as being independent when walking in room. On 4/29/2015 at 2:22 p.m., during an interview with the Maintenance Director (MD), the question was asked why a metal bar was across the thermostat in Resident #29's room. The MD walked into Resident #29's room and was observed to immediately kneel down on his knees, obtained a screwdriver from his pocket and remove the metal bar. The MD denied any knowledge of putting the metal bar over the thermostat during which Resident #29 became upset and indicated to the MD that he had been the one who did put the bar there. On 4/29/2015 at 3:05 p.m., with the Administrator present, Resident #29's thermostat was observed with two screw holes where the metal bar had previously been. The Administrator denied knowledge of the metal bar. Resident		determine any resident right violations or concerns. The results of the interviews will be submitted to the Administrator for immediate review when completed and then reviewed by the monthly Quality Assurance Committee for further recommendation. Any allegations of violations of Resident Rights will be corrected immediately and reported and investigated per policy. 5. Date of compliance: 6-3-15	

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	#29 indicated to the Administrator that he is comfortable now and is happy to be able to change the temperature himself. The Administrator indicated the thermostat should not have been like that and he cannot believe anyone would do that. On 4/30/2015 at 10:40 a.m., an interview with Certified Nursing Assistant (CNA #2) indicated Resident #29 is constantly cold. CNA #2 indicated she is constantly bringing the resident extra blankets and he always wears his coat. Sometimes she brings him a heating pad. CNA #2 denied knowledge of the metal bar across the thermostat. On 4/30/2015 at 11:04 a.m., License Practical Nurse (LPN #2) indicated Resident #29 always complains of being cold and wears his coat a lot. LPN #2 indicated she brings him more blankets and turns up his heat when he complains of being cold. When asked how Resident #29's heat can be turned up with a metal bar in place, LPN #2 denied knowledge of the metal bar. On 4/30/2015 at 10:55 a.m., during a follow up interview with Resident #29, he indicated the metal bar across his thermostat made him feel like a slave. He indicated he had no power and has been			

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	cold 95 percent of the time since he was admitted to the facility on 10/28/2014. Resident #29 also indicated he believed being cold had affected his body and had caused his health to deteriorate. On 5/01/2015 at 10:22 a.m., the Social Service Director (SSD) indicated the metal bar was put on by the current MD sometime in March. The metal bar was ordered by the former Administrator, because the room would get so hot it could be felt out in the hallway. The SSD indicated she was told by the current MD the temperature could still be adjusted to between 84 and 72 degrees however, Resident #29 could not see the thermostat and was not able to move freely around in his room in order to turn the heat up. Based on observation and record review Resident #29 was observed to propel freely in a wheelchair up and down hallway and the quarterly MDS completed on 4//6/2015, assessed Resident #29's functional status as being independent when walking in room. On 5/1/2015 at 10:38 a.m., a second interview with the MD indicated he had no knowledge of the metal bar being put across the thermostat and if he placed it there he doesn't remember doing so. He indicated no work order had been initiated for the placement of the metal			

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	155523		05/04/2015

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RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 W SR 46 ELLETTSVILLE, IN 47429

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	bar and he did not have temperature logs of where the room temperature had been measured in Resident #29's room. On 5/1/2015 at 2:27 p.m., the Administrator provided "Resident Rights" policy, undated, and indicated it was the policy currently used by the facility. The policy indicated, " ... A resident has the right to ... 3. make choices about aspects of his or her life in the facility that are significant to the resident. ..." 3.1-3(u)(3)			
F 247 SS=D Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure residents received notice prior to a roommate change for 2 of 3 residents reviewed for admission, transfer, and discharge notices. (Resident #8, Resident #9). Findings include: 1. Resident #8's clinical record was reviewed on 5/1/2015 at 1:00 p.m. The clinical record lacked documentation she	F 247	**F247** 1. Resident #8 and #9 were notified of room/roommate changes on 4/30/2015 by the Social Services Director. 2. And audit of current residents' medical record was completed of residents with room changes/roommate changes occurring since 4/23/2015 by the Social Services Director to determine if appropriate notification was	06/03/2015

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	had received notice of room mate changes. The quarterly MDS (Minimum Data Set) completed on 1/11/15, assessed Resident #8's BIMS (Brief Interview for Mental Status) as a 5 on a scale of 0-15. A score of 0-7 indicated the resident had severe cognitive impairment. On 4/24/15 at 12:28 p.m., an interview with Resident #8's daughter indicated Resident #8 has received many room mates without notice and she had told the facility they need to get her mother a permanent room mate. On 5/4/2015 at 3:00 p.m., the Social Services Director (SSD) provided the dates Resident #8 had received a new roommate. Resident #8 received a new roommate on 7/27, 10/31, and 11/2/2014. At that time, an interview with the SSD indicated there was no documentation which indicated Resident #8 received notice prior to the new roommate change. 2. Resident #9's clinical record was reviewed on 5/01/2015 at 11:15 a.m. Resident #9's clinical record lacked documentation she had received notice of a roommate change. .		made. Any missing notifications were made. 3. All staff were re-educated to The Right to Notice Before Room Change/Roommate Changes as of 6-2-15 with a reference to the requirement to complete the room change form and proper notification prior to a room change or roommate change. Room or Roommate changes will be discussed and reviewed by the Administrator in the daily Stand-Up meeting with the Interdisciplinary Team to determine that proper notifications and documentation was completed. 4. The right to notice before room change/roommate change documentation will be monitored by a chart audit of current residents with room/roommate changes to deterring that the proper notifications and documentation was completed for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. The audits will be completed by the Social Service Director and submitted to the Administrator for review. The results of the audits will then be reviewed in the monthly Quality Assurance Committee meeting for further recommendations. 5. Date of compliance:6-3-15	

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	The significant change MDS (Minimum Data Set) dated 2/10/15, assessed Resident 9's BIMS (Brief Interview for Mental Status) as a 9 on a scale of 0-15. A score of 8-12 indicated a resident was moderately impaired. On 04/24/2015 at 10:09 a.m., an interview with Resident #9 indicated she received a new roommate and no one notified her. On 5/4/2015 at 3:10 p.m., the Social Services Director (SSD) provided the dates Resident #9 had received a new roommate. Resident #9 received a new roommate on 9/19, and 11/7/2014. At that time, an interview with the SSD indicated there was no documentation which indicated Resident #9 received notice prior to the new roommate change. On 5/4/2015 at 1:30 p.m., requested policy for admission, transfer and discharge. The policy was never received. 3.1-3(v)(2)			
F 272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of			

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	each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on interview and record review the facility failed to ensure the MDS (Minimum Data Set) assessment was accurate for oral status for 1 of 35 residents whose clinical records were reviewed during stage 2 (Resident #62), and that staff accurately assessed residents' nutritional status on the Minimum Data Set (MDS) for 1 of 3	F 272	**F272** 1. The MDS assessment for Resident #62 was modified to reflect the presence of natural t to reflect the presence of natural teeth and resubmitted on 5/1/2015 by the MDS Coordinator. The MDS assessment for Resident #81 was modified to reflect weight loss of 5%	06/03/2015

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	residents screened for nutritional status. (Resident #81). Findings include: 1. Resident #62's clinical record was reviewed on 4/30/2015 at 11:15 a.m. Diagnoses included, but were not limited to coronary artery disease. On 04/24/2015 at 3:01 p.m., an observation of Resident #62's mouth indicated she had 4 teeth on bottom. At that time, she indicated she had not been to a dentist in awhile. The annual MDS (Minimum Data Set) completed on 2/15/15, assessed Resident #62 as having no natural teeth, and was edentulous. On 5/1/2015 at 9:40 a.m., an interview with the MDS coordinator indicated that the MDS was inaccurate when it identified Resident #62 as having no natural teeth and was edentulous. On 5/1/2015 at 12:00 p.m., requested policy for MDS assessments. The DON (Director of Nursing) indicated the facility uses the CMS (Centers for Medicaid and Medicare) RAI (Resident Assessment Instrument) as a policy.		and resubmitted on 5/1/2015 by the MDS Coordinator. 2. An audit of the most recent MDS assessment of current residents was completed by Licensed Nurses as of 6-2-15 by comparing the MDS assessment to the resident to determine the accuracy of the assessment which included resident oral and weight status. Any errors identified were corrected and the MDS resubmitted. 3. The MDS Coordinator, Regional Dietician, Social Services, and Activities Director were re-educated by the Director of Nursing to the RAI process and completing assessments that accurately reflect the residents status as of 6-2-15. 4. An audit will be conducted by the Director of Nursing/MDS Coordinator or designee on 5 MDS assessments by comparing the MDS to the resident to determine that the assessment accurately reflects the residents status weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation.	

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	2. Resident #81's clinical record was reviewed on 3/30/15 at 10:22 a.m. Diagnosis included, but were not limited to: dehydration, gastronomy tube (feeding tube), and nutritional deficiency. A review of Resident #81's vitals report indicated the following: On 02/12/15, the resident weighed 165.2 pounds on admission to the facility. On 02/20/15, the resident weighed 164.2 pounds. On 03/04/15, the resident weighed 156.2 pounds. This was a 5.21% of weight loss since admission. On 04/24/15, the resident weighed 152.8 pounds. A nutrition therapy update form, dated 3/9/15, indicated, "Wt. [weight] loss 156.6# [pounds] (3/5/15). ... diet of pureed [ground, pressed or strained food to a consistency of a soft, smooth, thick paste] with nectar liquid [thickened liquid that helps people to swallow] with direct supervision. This may preclude an additional tube feeding increase to promote appetite and po [by mouth] intake..."		5. Date of compliance: 6/3/2015	

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	The 30 day scheduled MDS, dated 03/15/15, indicated the resident weighed 157 pounds, which was rounded up from the actual weight of 156.2 pounds. The MDS did not indicate a loss of 5% in the last month. During an interview, on 05/01/15 at 9:42 a.m., the MDS coordinator indicated the Dietary Manager is responsible for filling out section K, Swallowing/Nutritional Status. She further indicated the 3/15/15, MDS should have indicated weight loss. Section K on Resident #81's MDS was signed as completed by the MDS coordinator and the Dietary Manager on 3/15/15. 3.1-31(b)(5) 3.1-31(b)(9)			
F 278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the			

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	appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on interview and record review, the facility failed to ensure staff accurately assessed residents nutritional status on the Minimum Data Set (MDS) for 1 of 3 residents screened for nutritional status. (Resident #81) Findings include: Resident #81's clinical record was reviewed on 3/30/15 at 10:22 a.m. Diagnosis included, but were not limited to: dehydration, gastronomy tube (feeding tube), and nutritional deficiency.	F 278	**F278** 1. The MDS assessment for Resident #62 was modified to reflect the presence of natural teeth and resubmitted on 5/1/2015 by the MDS Coordinator. The MDS assessment for Resident #81 was modified to reflect weight loss of 5% and resubmitted on 5/1/2015 by the MDS Coordinator. 2. An audit of the most recent MDS assessment of current residents was completed by Licensed Nurses as of 6-2-15 by	06/03/2015

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	A review of Resident #81's vitals report indicated the following: On 02/12/15, the resident weighed 165.2 pounds on admission to the facility. On 02/20/15, the resident weighed 164.2 pounds. On 03/04/15, the resident weighed 156.2 pounds. This was a 5.21% of weight loss since admission. On 04/24/15, the resident weighed 152.8 pounds. A nutrition therapy update form, dated 3/9/15, indicated, "Wt. [weight] loss 156.6# [pounds] (3/5/15). ... diet of pureed [ground, pressed or strained food to a consistency of a soft, smooth, thick paste] with nectar liquid [thickened liquid that helps people to swallow] with direct supervision. This may preclude an additional tube feeding increase to promote appetite and po [by mouth] intake..." The 30 day scheduled MDS, dated 03/15/15, indicated the resident weighed 157 pounds, which was rounded up from the actual weight of 156.2 pounds. The MDS did not indicate a loss of 5% in the last month.		comparing the MDS assessment to the resident to determine the accuracy of the assessment which included resident oral and weight status. Any errors identified were corrected and the MDS resubmitted. 3. The MDS Coordinator, Regional Dietician, Social Services, and Activities Director were re-educated by the Director of Nursing to the RAI process and completing assessments that accurately reflect the residents status as of 6-2-15. 4. An audit will be conducted by the Director of Nursing/MDS Coordinator or designee of 5 MDS assessments by comparing the MDS to the resident to determine that the assessment accurately reflects the residents status weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation. 5. Date of compliance: 6-3-15	

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	During an interview, on 05/01/15 at 9:42 a.m., the MDS coordinator indicated the Dietary Manager is responsible for filling out section K, Swallowing/Nutritional Status. She further indicated, the 3/15/15 MDS should have indicated weight loss. Section K on Resident #81's MDS was signed as completed and accurate by the MDS coordinator and the Dietary Manager on 3/15/15. 3.1-31(h) 3.1-31(i)			
F 279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services			

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	that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review, the facility failed to ensure a care plan had been created for ADL (Activities of Daily Living)/Rehabilitation Potential as the CAA (Care Area Assessment) summary indicated on the MDS (Minimum Data Set) assessment for 1 of 5 residents reviewed for rehabilitation (Resident #62), and resident who received an anti-depressant medication for 1 of 5 residents reviewed for unnecessary medication use (Resident #29), and for residents receiving mood stabilizers medication for 1 of 5 resident reviewed for unnecessary medication use (Resident #48), and refusal of care for 1 of 4 residents interviewed for allegations of abuse (Resident #2). Findings include: 1. Resident #62's clinical record was reviewed on 4/30/2015 at 11:15 a.m. Diagnoses included, but were not limited to coronary artery disease and diabetic peripheral neuropathy. The annual MDS (Minimum Data Set) assessment, completed on 2/15/2015, assessed Resident #62 as needing one	F 279	**F279** 1. A care plan was written for resident #62 related to ADLs on 5/1/2015 by a licensed nurse. A care plan was written for resident #29 for the use of an antidepressant on 4/30/2015 by a licensed nurse. A care plan for the use of Depakote was written for resident #48 on 5/1/2015 by a licensed nurse. A care plan for resident #2 was written related to refusal of care on 5/1/2015 by a licensed nurse. 2. A care plan audit was completed on current residents in the facility by the Interdisciplinary team as of 6-2-15. Care plans were reviewed to determine they were comprehensive and accurate as indicated by the CAAs or residents medical record and/or status. Any concerns identified were corrected at that time. 3. Resident care plans will be reviewed quarterly for accuracy and to determine that they are comprehensive and updated as indicated by the Interdisciplinary Team. The MDS Coordinator, Social Services Director, Activity Director was re-educated by the Director of	06/03/2015

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	person physical assist with transferring, physical help with part of bathing, not steady but able to stabilize without staff assistance, and uses wheelchair for mobility. The functional Rehabilitation Potential was not completed. Review of Resident #62's careplans indicated no careplan for ADL's (Activities of Daily Living). The annual MDS (Minimum data Set) identified ADL's as a CAA (Care Area Assessment) that the facility would careplan. On 5/1/2015 at 1:28 p.m., an interview with the MDS Coordinator indicated she is responsible for initiating care plans that trigger from the MDS CAA's summary. At that time, she indicated Resident #62 had a ADL/Functional Rehabilitation Potential careplan which "fell off" in January 2015, so she would reinitiate one now. On 5/1/2015 at 12:00 p.m., the DON (Director of Nursing) provided the "Care Plan" policy dated 4/1/2012, and indicated it was the policy was the one currently being used by the facility. The policy indicated, " ...4. Areas of concern triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before		Nursing as of 6-2-15 on developing accurate, comprehensive Care Plans. 4. The MDS, resident and resident Care plan of 5 residents will be audited by the MDS Coordinator/Director of Nursing or designee for accuracy and to determine that the care plan is comprehensive and accurate weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be corrected at that time. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation. 5. Date of compliance: 6-3-15	

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	interventions are added to the care plan. 5. Within seven days after the completion of the MDS the resident's comprehensive care plan will be developed, reviewed and revised as applicable. The MDS will serve as a minimum assessment tool to identify problems and needs for care planning...." 2. The clinical record was reviewed for Resident #29 on 4/30/2015 at 11:05 a.m. Diagnoses included, but were not limited to depression and dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/6/2015, assessed Resident #29 as taking an anti-depressant medication the last 7 out of 7 days. Physicians order dated 4/1/2015, indicated Resident #29 medications included but, were not limited to: Celexa (an anti-depressant) 10 milligrams, give 1/2 tablet (5 milligrams) once a day. The original start date was 1/6/2015. On 4/30/2015 at 1:05 p.m., the Director of Nursing (DON) provided Resident #29's current and undated care plan. No care plan had been initiated for the use of anti-depressant medications for Resident #29. On 4/30/2015 at 3:06 p.m., an interview with License Practical Nurse (LPN #3)			

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	indicated Resident #29 did not have a care plan for the anti-depressant medication, Celexa. On 4/30/2015 at 4:25 p.m., the DON provided an updated care plan dated 4/30/2015, for the anti-depressant medication Celexa, and indicated the care plan had just been created that day. On 5/1/2015 at 12:00 p.m., the DON provided "Care Plan" policy dated 4/1/2012, and indicated it was the policy currently used by the facility. The policy indicated, " ... Social service staff will assure residents receiving mood altering medications and/or psychotherapy have this need addressed in their care plan and monitor interventions and outcomes. ..." 3. Resident #48's clinical record was reviewed on 4/30/15 at 12:06 p.m., Diagnosis included but were not limited to: depression, anxiety and renal cancer. Resident #48 was admitted to the facility on 11/17/13. The current Minimum Data Set assessment dated 1/12/15, indicated a Brief Interview Mental Status of 9, which was interviewable and mildly cognitively impaired. Physician's order dated 4/11/15, indicated			

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	155523		05/04/2015

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	"...DEPAKOTE 125 (mg) milligram SPRINKLE GIVE 2 CAPSULES [250 MG] ORALLY AT BEDTIME FOR MOOD" On 4/30/15 at 3:50 p.m., the Director of Nursing (DON) indicated there was no care plan for mood stabilizer available for Resident #48's Depakote medication. On 5/1/15 at 9:15 a.m., the DON provided "Behavioral Symptoms" care plan dated 5/1/15. The care plan indicated, "Attention seeking-Yelling out inappropriately. ...Goal : Resident will have fewer episodes of yelling out, ... Approach: Administer and monitor the effectiveness and side effects of medications ... Depakote ..." 4). Resident #2's clinical record was reviewed on 4/29/15 at 10:32 a.m. Diagnosis include, but were not limited to: bipolar disorder, depressive disorder insomnia, and schizoaffective. The current Minimum Data Set assessment dated 2/12/15, indicated a Brief Interview for Mental Status score was 11, indicated interviewable and mildly cognitively impaired.. Care plan dated 8/4/14, "ADL Functional/Rehabilitation Potential.			

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	Resident requires limited assist of one with ADL's due to mobility issues secondary to BKA (below knee amputation). ... Goal: Resident will have needed assistance with ADL's (Activity of Daily Living) and will be clean and well-groomed ... Approached: Provide limited assistance as needed with dressing, hygiene, bathing and supervision with transfers and toileting... Assist with oral care, ...If refuses assistance, make sure resident is safe and return at a later time to assist...." On 4/30/15 at 11:45 a.m., CNA (Certified Nursing Assistant) #5 indicated Resident #2 wants to do everything independently. . Resident #2 refuses to let staff transfer him. When Resident #2 is up in wheelchair he empties his own catheter. On 5/3/15 at 4:50 p.m., RN #3 indicated Resident #2 had a habit of refusing showers and then will say he didn't get one. Resident #2 likes to do things on his own. On 5/1/15 at 2:30 p.m., Review of care plans with the Social Service Director indicated there was no care plan specific to Resident #2's behavior of refusal of care.			

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	On 5/1/15 at 1:25 p.m., the Social Service Director provided careplan "Refusal of care" dated 5/1/15. On 5/1/15 at 12:00 p.m., the Director of Nursing provided policy "CAREPLAN" dated 4/1/12 and indicated the policy was the one currently used by the facility. The policy indicated, " ... A preliminary care plan is developed within 24 hours of admission to assure the resident's immediate care needs are met. ... 2. a. Incorporate identified problem areas; ... 5. Within seven days after the completion of the MDS the resident'[comprehensive care plan will be developed, ...9. Social Service staff will assure residents receiving mood altering medications ...have this need addressed in their care plan and monitor interventions and outcomes. ..." 3.1-35(a) 3.1-35(b)(1)			
F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure	F 282	F282	06/03/2015

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	implementation of physician orders for a resident who had orders for accuchecks to monitor blood sugars for 1 of 5 residents reviewed for unnecessary medication use. (Resident #8) Findings include: Resident #2's clinical record was reviewed on 4/29/15 at 10:32 a.m. Diagnosis include, but were not limited to: diabetes type II. Physicians order dated 7/2/13, indicated, "ACCUCHECKS BEFORE MEALS." Careplan dated 8/4/14, Resident has diabetes and is at risk for hyper/hypoglycemia. Goal Resident will remain free of hyper/hypoglycemia and blood sugars will remain WNL (within normal limits). ...Approach ...labs per order ... monitor blood sugars, monitor for s/s (signs and symptoms) hypoglycemia (drowsiness, headache, slurred speech, sweating, increased pulse) ... hyperglycemia (increased respiration, abdominal pain, frequent urination, lethargy ..." Review of the Medication Administration Records the following dates lack documentation of blood sugar being monitored as ordered by the physician:		1. Resident #2 was assessed by a Licensed nurse with no adverse affects noted and the MD and family were notified on 5/24/2015 of the missed blood glucose monitoring and residents current status. 2. An audit of the current residents MARS and TAR was completed as of 6-2-15 by the Director of Nursing and designees to identify any missed administrations. Any concerns identified were followed by a resident assessment and MD/family notification. No adverse effects were noted. 3. All nurses were re-educated on the expectation that MD orders are completed and documented as appropriate on the MAR and/or TAR by the Director of Nursing and Unit Manager as of 6-2-15. The Charge nurses will review MAR/TAR documentation to include but not limited to blood glucose monitoring at the end of each shift. 4. An audit will be conducted by the Director of Nursing or designee for completion of documentation in the MAR/TAR as appropriate and to include but not be limited by the monitoring of blood glucose levels weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results	

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	1/6/15 at 4:30 p.m., 1/7/15 at 6:00 a.m., 11:30 a.m., 4:30 p.m., 1/21/15 at 4:30 p.m., 1/24/15 at 4:30 p.m., 2/13/15 and 2/14/15 at 4:30 p.m., 2/18/15 at 6:00 a.m., 2/19/15 at 11:30 a.m., and 4:30 p.m., 2/27/15 at 6:00 a.m., 3/3/15 at 11:30 a.m., and 4:30 p.m., 3/10/15 at 11:30 a.m., and 4:30 p.m., 3/12/15 at 6:00 a.m., 3/19/15 at 4:30 p.m., 3/27/15 at 6:00 a.m., and 4:30 a.m., 4/10/15 at 4:30 p.m., 4/21/15 at 4:30 p.m., and 4/23/15 at 4:30 p.m., On 04/30/2015 at 3:46 p.m. the DON indicated, the facility does not have separate glucose monitoring or diabetic flow sheets which in this case would have saved them from this issue. 3.1-35(g)(2)		of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation. 5. Date of compliance: 6-3-15	
F 286 SS=C Bldg. 00	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. Based on record review and interview,	F 286		06/03/2015

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	the facility failed to maintain 15 months of Minimum Data Set (MDS) assessments in a location that was readily and easily accessible to all professional staff including the consultants. This deficient practice had the potential to affect all 77 residents who reside in the facility. Findings include: During record review of MDS (Minimum Data Set) assessment for the 35 residents reviewed in stage 2 indicated that the residents' chart did not contain any MDS. Professional staff were unable to access residents MDS assessment without asking the Director of Nursing (DON) or the MDS Coordinator. On 4/29/2015 at 11:00 a.m., an interview with the MDS Coordinator indicated there were no printed copies of MDS assessments for the residents. The assessments were located in the computer charting system. At that time, she indicated the nurses did not have access to this information and someone in Management would have to print the assessments out for the nurse if they needed it. On 4/30/2015 at 1:30 p.m., an interview with the DON (Director of Nursing)		**F286** 1. Licensed nurses were provided access to the electronic charting system as of 6-2-15 that enables them to view all of the residents MDS assessments. 2. Licensed nurses were provided access to the electronic charting system as of 6-2-15 that enables them to view all residents MDS assessments. 3. Licensed nurses were provided access to the electronic charting system in order to view all current residents MDS assessments and were educated by the Director of Nursing and MDS nurse on how to use the system and locate and view the MDS assessments as of 6-2-15. Newly hired nurses will be provided with access to the electronic charting system and educated on how to navigate to the MDS assessments upon hire. 4. And audit will be conducted by the MDS Coordinator or designee with 5 licensed nurses weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months to determine their ability to access and view the residents MDS assessments. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the monthly Quality	

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	indicated she did not realize the nurses did not have access to the MDS assessments in the computer system. She indicated the MDS coordinator was going to print out the assessments and place them in binders so they would be accessible. On 5/1/15 at 12:00 p.m., the DON provided the CMS's RAI (Resident Assessment Instrument) Version 3.0 Manual dated October 2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments: "The Federal regulatory requirement...requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record... must also ensure that clinical records, regardless of form, are easily and readily accessible to all staff (including consultants)...and others who are authorized by law and need to review the information in order to provide care to the resident..."		Assurance Committee for further recommendation. 5. Date of compliance: 6-3-15	
F 312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out			

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	activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure a resident received assistance to receive the required number of showers for 1 of 3 residents reviewed for choices. (Resident #62) Findings include: Resident #62's clinical record was reviewed on 4/30/2015, at 11:15 a.m. Diagnoses included, but were not limited to coronary artery disease, diabetic peripheral neuropathy, diabetes mellitus type 2, dizziness, giddiness, hypertension, hyperlipidemia and insomnia. The quarterly MDS (Minimum Data Set) assessment, completed on 3/27/2015, assessed Resident #62's BIMS (Brief Interview for Mental Status) score as a 13, on a scale of 0-15. A score of 13, indicated she was cognitively intact and interviewable. The functional status assessment indicated she needed some physical assistance with bathing, setup help only. On 04/24/2015 2:41:19 p.m., an interview with Resident #62 indicated	F 312	**F312** 1. Resident #62 was interviewed about preferences for showers for bathing and the CNA assignment sheet and care plan were reviewed and updated by a licensed nurse on 5-24-15 to indicate the resident's preference for showers for bathing. Resident #62 has ADL care provided, including showers, as indicated in the plan of care. 2. All resident preferences were reviewed for accuracy on the CNA assignment sheets and care plans as of 6-2-2015. Shower documentation for current residents was reviewed by the Director of Nursing and designee to determine that ADL care, including showers, had been administered as per the plan of care. 3. A new system of shower sheets was developed to include a full page sheet, resident signature for refusals and a system for filing shower sheets to facilitate an audit process. Nursing staff have been re-educated on providing ADL care for dependent residents including but not limited to bathing, and completing the required documentation by the Director of Nursing or designee as of 6-2-15.	06/03/2015

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	she gets 2 showers a week on Wednesday and Saturday. She only received one this week. On 4/30/2015 at 1:04 p.m., the DON provided the shower sheets for Resident #62. The shower sheets indicated on: 4/15/2015, she received a shower. 4/25/2015, she received a shower. 4/28/2015, she received a shower. No shower sheet provided for 4/22/2015. On 4/30/2015 at 1:05 p.m., an interview with the DON indicated she could not find the shower sheet for that day. On 4/30/2015 at 2:20 p.m., review of Resident #62's preference sheet indicated showers for bathing ask resident. On 4/30/2015 at 3:00 p.m., requested policy for showers, no policy was provided for showers. On 5/1/15 at 12:00 p.m., the Director of Nursing provided the " Documentation in the Clinical Record" policy dated 6/4/2012, and indicated the policy was the one currently being used by the facility. The policy indicated: " ...Procedure: 1. Observations, medications administered, services performed, etc., are documented in the resident ' s clinical records ...."		4. An audit of 5 residents will be conducted by the Director of Nursing or designee to determine that ADL care, including showers/baths, was provided as indicated in the plan of care weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the Quality Assurance Committee for further recommendation. 5. Date of compliance: 6-3-15	

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	3.1-38(a)(3)			
F 329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 residents who	F 329	F329	06/03/2015

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	received an anti-psychotropic medication were monitored for side effects and behaviors for 5 out of 5 residents reviewed for unnecessary medication use. (Resident #29, Resident #117, Resident #81, Resident #2 and Resident #48). 1. Resident #2's clinical record was reviewed on 4/29/15 at 10:32 a.m. Diagnosis included, but were not limited to: bipolar disorder, depressive disorder insomnia, and schizoaffective. The current Minimum Data Set assessment dated 2/12/15, indicated a Brief Interview for Mental Status score of 11, indicating interviewable and mildly cognitively intact. Resident #2 admitted to the facility on 7/2/13. Physician's order dated 5/1/15-5/31/15, indicated Resident #2 received 150 (mg) milligrams of bupropion hcl (antidepressant/Wellbutrin) since 6/20/14; 250 mg of Depakote daily since 11/14/14 (anticonvulsant/mood stabilizer); and 10 mg of Ambien at night as needed (hypnotic/sedative) since 7/2/13. On 4/18/15 Ambien 10 mg was ordered daily at night. Lippincott, Williams and Wilkins		1. Resident #2's MAR and Behavior Monitoring Sheet has been updated to reflect changed to monitor for side effects of Buproprion hcl, Depakote, and Ambien and was assessed by a licensed nurse on 4/30/2015 with no side effects noted. . Resident #48's MAR and Behavior Monitoring Sheet has been updated to monitor for behaviors and side effects related to the use of the Depakote, Zoloft, and Xanax and was assessed by a licensed nurse and an AIMS assessment completed on 4/24/2015 with no side effects noted. **2.** Resident #117's Behavior Monitoring Sheet has been updated to include the monitoring for side effects related to the use of Lexapro and Ativan and was assessed by a licensed nurse with no side effects noted on 4/20/2015. Resident #8l'sBehavior Monitoring Sheet has been updated to monitor for side effects related to the use of Fluoxetine and Risperidone and was assessed by a licensed nurse with no side effects noted on 5/20/2015 . Resident #29's Behavior Monitoring Sheet has been updated to monitor for side effects related to the use of Celexa and was assessed by a licensed nurse with no side effects noted on 4/30/2015 . 3. The Behavior Monitoring	

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	Nursing Drug Handbook 2014, indicated side effects for Ambien included but were not limited to: headache, depression, drowsiness, lethargy, light-headedness, nervousness, abdominal pain, diarrhea, dry mouth and myalgia [muscle pain]. Bupropion hcl side effect included but were not limited to: insomnia, headache, sedation, tremor, agitation, dizziness, seizures, suicidal behavior, anxiety, confusion, delusion, hostility, akinesia [loss or impairment of voluntary muscles] and syncope [temporary loss of consciousness] Depakote side effects included but were not limited to:asthenia (loss of strength), headaches, insomnia, nervousness, tremor, abnormal thinking, amnesia (loss of memory), ataxia (loss of coordination), hypertension, hypotension, pancreatitis (inflammation of the pancreas) and hemorrhage (bleeding in or out of the body). Behavior Intervention Monthly flow record (form) for January, March and April 2015, lacked documentation in the side effects section that potential side effects of medication were being monitored for Ambien, bupropion hcl, and Depakote. The Director of Nursing		Sheets for current residents receiving psychoactive drugs was updated by a licensed nurse as of 6-2-15 to include the behaviors related to the use of the medication and the monitoring of side effects for each psychotropic drug. 4. Behaviors and potential side effects for psychotropic medications are monitored every shift by licensed nursing staff. All Nurses will be re-educated to the Behavior Monitoring program and how to complete the Behavior Monitoring Sheets in regards to the episodes of behaviors and side effects related to the use of psychotropic medications as of 6-2-15 by the Director of Nursing or designee. 5. An audit of 5 residents on psychotropic medications will be conducted by the Director of Nursing or designee to determine that Behavior Monitoring Sheets are in place for each psychotropic medication ordered, the related behavior being addressed by the medication and the potential side effects that are to be monitored weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation.	

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(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
	(DON) indicated unable to find the February Behavior Intervention Monthly flow (forms). Therefore, no documentation was provided indicating side effects for Ambien, bupropion hcl, and Depakote were being monitored. The Behavior Intervention Monthly flow record (form), lack documentation for monitoring behaviors for bupropion and Ambien were being monitored on night shift for 1/23/15, 3/1/15, 3/19/15, and 4/28/15. There was no documentation behaviors were being monitored for bupropion and Ambien on dayshift nor nightshift for 4/29/15, and 4/30/15. The Abnormal Involuntary Movement Scale (AIMS) lacked documentation April 2015 AIMS had been completed, as indicated by Resident #2's care plan. The current care plan "episodes of insomnia" dated 8/4/14, indicated, "... Approach ... monitor for side effects of medication." The current care plan "Mood State" dated 8/4/14, indicated, "... Resident has diagnosis of depression and experiences sadness at time. Resident will be free of s/s of depression, ...Approach ... monitor for symptoms of depression (insomnia, crying, self-imposed isolation, anorexia,		6. Date of compliance: 6-3-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/04/2015
NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429	

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	etc) record in progress notes ..." Care plan dated 8/4/14 indicated "Resident is at risk for adverse reactions related to the use of Wellbutrin for depression, and Ambien prn [as needed] for insomnia, Depakote for refractory depression. ...Goal ... no adverse reactions to the use of antidepressant, ... and hypnotic medication, ..Approach ... AIMS (Abnormal Involuntary Movement Scale) testing upon admission, quarterly and prn. ... Monitor for adverse reactions to the medication." On 4/29/15 at 10:37 a.m., interview with RN #2 indicated nurses only chart on side effects for 3 days after the start of a medication. On 4/29/15 at 10:40 a.m., the Director of Nursing (DON) indicated she was not sure how the nurses monitored for side effects on psychotropic medications on the Behavior Intervention Monthly flow sheet. On 4/30/15 at 10:28 a.m., LPN #1 indicated she was not aware how the Behavior Intervention Monthly Flow sheets were used for monitoring side effects of psychotropic medications. LPN #1 indicated "Something's are monitored every shift or daily depending			

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	on the side effect." LPN#1 indicated she would have to use the drug book to find out what the side effects were for Resident #2's medications. On 5/1/15 at 9:40 a.m., the DON indicated the behaviors indicated on the care plan should also be reflected on the Behavioral Intervention Monthly flow sheet. The DON indicated the Behavioral Intervention Monthly flow sheet needed to be updated and the blank spaces indicated behaviors and side effects had not been monitored. On 5/1/15 at 10:10 a.m., the Social Service Director indicated, the care plan was a generic one for Antidepressants and Antianxiety. The behaviors on the care plan should match the behaviors on the behavioral sheet. The Social Service Director and the Minimum Data Set coordinator (MDS) present indicated, there was no behavior/side effect monitoring sheet for Depakote which Resident #2 was receiving for refractory depression (treatment resistance). On 4/29/15 at 3:15 p.m., the DON indicated there was no policy for monitoring side effects however, the facility follows the Abnormal Involuntary Movement Scale (AIMS) guidelines and one is done on admission, quarterly, with			

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	any significant change and any change in the Antipsychotic drugs. On 4/30/15 at 9:30 a.m., the Director of Nursing (DON) indicated the facility does not have a policy for when and how often to monitor for side effects of psychotropic medications. 2. Resident #48's clinical record was reviewed on 4/30/15 at 12:06 p.m., Diagnosis included but were not limited to: depression, anxiety and renal cancer. The current Minimum Data Set assessment dated 1/12/15, indicated a Brief Interview Mental Status of 9 which was interviewable and cognitively intact. Resident #48 admitted to the facility on 11/17/13. Physician's order dated 5/1/15-5/31/15, indicated Resident #48 received 250 (mg) milligrams of Depakote sprinkles at night since 4/11/15 for mood stabilizer after 2 dose reductions on 7/2/14 and 2/6/15; Xanax 0.25 mg three times a day for anxiety since 12/9/14; and Zoloft 150 mg daily for depression since 7/2/14. Lippincott, Williams and Wilkins Nursing Drug Handbook 2014, indicated, side effects for Depakote included, but			

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	were not limited to: asthenia (loss of strength), headaches, insomnia, nervousness, tremor, abnormal thinking, amnesia (loss of memory), ataxia (loss of coordination), hypertension, hypotension, pancreatitis (inflammation of the pancreas) and hemorrhage (bleeding in or out of the body). Xanax's side effects included, but were not limited to: insomnia, irritability, anxiety, confusion, impaired speaking, impaired coordination, suicide, depression, mania, and tremor. Zoloft's side effects included, but were not limited to: headache, tremor, insomnia, suicidal behavior, paresthesia (perverted sensations), and diarrhea. Behavior/Intervention Monthly Flow Record dated March-April 2015, lacked documentation side effects were monitored (column blank) for Resident #48's Xanax and Zoloft medications. The Director of Nursing (DON) indicated unable to find the February 2015, Behavior Intervention Monthly flow (forms). Therefore, no documentation was provided indicating side effects for Xanax and Zoloft were being monitored. The Behavior Intervention Monthly flow record (form), lack documentation for			

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	monitoring behaviors for Xanax and Zoloft on dayshift for 3/4//15, 3/16/15, 4/1/15, 4/3/15, 4/4/15, 4/25/15, and 4/30/15 on nightshift. There was no Behavior/Intervention Monthly Flow Record provided for monitoring side effects nor behaviors for Depakote. There was no documentation side effects were being monitored for the Zoloft and Xanax medications for Resident #48. Care plan "Depression" dated 10/22/14, indicated "Pt is on Zoloft" ... Approach ...monitor for side effects of antidepressant, ...record in progress notes, ..." Care plan "... risk for adverse reactions related to the use of Xanax, Depakote and Zoloft" dated 10/22/14, ... Approach ... AIMS (The Abnormal Involuntary Movement Scale) testing upon admission, quarterly, and prn. ... Monitor for adverse reactions to the medication use: lethargy, slurred speech, tremors, restless leg movement, ticks. ..." There was no Abnormal Involuntary Movement Scale (AIMS) completed for March 2015, as indicated by Resident #48's care plan.			

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	On 4/30/15 at 10:35 a.m., RN #1 indicated nursing staff uses the Abnormal Involuntary Movement Scale (AIMS) to monitor for side effects of Antipsychotic medications quarterly and annually, but no monitoring of antidepressants and Antianxiety medication side effects. The behavior monitoring sheet was only used to track behaviors not side effects. RN #1 indicated when a new medication was started the side effects would be monitored for 3 days and after 3 days the side effects are not documented unless something was wrong. On 4/29/15 at 3:15 p.m., the DON indicated there was no policy for monitoring side effects, however the facility follows the Abnormal Involuntary Movement Scale (AIMS) guidelines and one is done on admission, quarterly, with any significant change and any change in the Antipsychotic drugs. On 4/30/15 at 9:30 a.m., the Director of Nursing (DON) indicated the facility does not have a policy for when and how often to monitor for side effects of psychotropic medications On 4/30/15 at 3:50 p.m., the DON indicated there was no care plan for mood stabilizer available for Resident #48's Depakote medication.			

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	On 5/1/15 at 12:00 p.m., the Director of Nursing provided policy "CAREPLAN" dated 4/1/12 and indicated the policy was the one currently used by the facility. The policy indicated, " ... 9. Social Service staff will assure residents receiving mood altering medications ...have this need addressed in their care plan and monitor interventions and outcomes. ..."3. Resident #117's clinical record was reviewed on 5/1/15 at 11:03 a.m. Diagnosis included, but were not limited to: anxiety and depression. Resident #117's medications included: Lexapro 10 milligrams (mg) daily (antidepressant), Ativan 0.5 mg as needed (anti-anxiety medication), and Xanax 0.25 mg three times daily (anti-anxiety medication) Resident #117's current careplans included, but were not limited to: "Problem: Resident has diagnosis of depression (start date 4/20/15). ...Approach: ...Monitor for side effects of antidepressant medication. Monitor for symptoms of depression (insomnia, crying, self-imposed isolation, anorexia, etc.) ..." "Problem: Resident is at risk for			

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	alteration in mood/behavior due to diagnosis of anxiety (start date of 4/20/15). ...Approach: Administer medications as ordered by MD and monitor for side effects [sic] and effectiveness. ativan..." Resident #117's clinical record lacked documentation for side effect monitoring for the medications Lexapro and Ativan. During an interview, on 4/30/15 at 11:32 a.m., LPN #3 indicated she was unsure if the residents were being monitored for side effects. She further indicated she knows her residents very well and she would notice if they experienced any side effects from medications. LPN #3 indicated she would obtain documentation that the facility was monitoring for side effects, however, no documentation was provided. 4. Resident #81's clinical record was reviewed on 4/30/15 at 9:41 a.m. Diagnosis included, but was not limited to: Alzheimer's dementia with behavioral disturbances and depression. Resident #81's medications included: Risperidone 0.25 milligrams (mg) two times daily (antipsychotic medication) and fluoxetine 10 mg daily (antidepressant medication).			

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	Resident #81's current careplans included, but were not limited to: "Problem: Attention seeking- AEB [as evidence by] being verabal [sic] with staff in the past and refusing care (start date 2/12/15). ...Approach: Administer and monitor the effectiveness and side effects of medications as ordered..." "Problem: Resident has diagnosis of depression. Pt [patient] is on fluoxetine (start 2/12/15). ...Approach: Monitor for side effects of antidepressant medications..." Resident # 81's clinical record lacked documentation for side effect monitoring for the medications fluoxetine and risperidone. During an interview, on 4/30/15 at 11:32 a.m., LPN #3 indicated she was unsure if the residents were being monitored for side effects. She further indicated she knows her residents very well and she would notice if they experienced any side effects from medications. LPN #3 indicated she would obtain documentation that the facility was monitoring for side effects, however, no documentation was provided. 5. The clinical record was reviewed for			

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	Resident #29 on 4/30/2015 at 11:05 a.m. Diagnoses included, but were not limited to depression and dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/6/2015, assessed Resident #29 as taking an anti-depressant medication the last 7 out of 7 days. Physicians order dated 4/1/2015, indicated Resident #29 medications included but, were not limited to: Celexa (an anti-depressant) 10 milligrams, give 1/2 tablet (5 milligrams) once a day. The original start date was 1/6/2015. The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, list side effects for Celexa include, but are not limited to: anxiety, agitation, dizziness, orthostatic hypotension, nausea, diarrhea, vomiting, increased or decreased weight. On 4/30/2015 at 1:05 p.m., Director of Nursing (DON) provided Resident #29's current and undated care plan. No care plan had been initiated for the use of anti-depressant medications for Resident #29. The clinical record lacked documentation which indicated side effects were being monitored for Resident #29's Celexa.			

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	During an interview, on 4/30/15 at 11:32 a.m., LPN #3 indicated she was unsure if the residents were being monitored for side effects. She further indicated she knows her residents very well and she would notice if they experienced any side effects from medications. 3.1-48(a)(3)			
F 371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to display food under sanitary conditions in the dining room as indicated by the Retail Food Establishment Sanitation Requirement in that resident's drinks were on the dining room tables uncovered and unattended dining room for 15 of 17 dining room tables for 1 of 1 dining room. Findings include: On 4/23/15 at 12:10 p.m. the following	F 371	**F371** 1. Current residents who receive meals in the dining room were assessed by a licensed nurse for any adverse effects related to drinks not being covered when served in the dining room and no adverse effects were noted on 5-23-15. 2. Current residents who receive meals in the dining room were assessed by a licensed nurse for any adverse effects related to drinks not being covered when served in the dining room and no adverse effects were noted on 5-23-15. 3. The kitchen provides contained/covered drinks to the dining room and the	06/03/2015

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	resident's drinks were observed on their tables uncovered and resident was not present: (Resident #67, Resident #30, Resident #8, Resident #63, Resident #75, Resident #88, Resident #55) On 4/30/15 at 4:00 p.m., observed 15 out of 17 tables in the dining room to have uncovered beverages on the tables with no residents present. At 4:30 p.m. 2 residents were observed in the dining room at the table. On 5/1/15 at 11:50 a.m., dietary staff indicated drinks should be covered if sitting on the table and residents are not present. Retail Food Establishment Sanitation Requirement dated 11/13/2004, indicated "... 410 IAC 7-24-179 Food display Sec. 179. (a) Except for nuts in the shell and whole, raw fruits and vegetables that are intended for hulling, peeling, or washing by the consumer before consumption, food on display shall be protected from contamination by the use of: (1) packaging, ... (3) display cases; or (4) other effective means. ..." 3.1-21(i)(3)		nursing staff offers and serves each resident their choice of drink when arriving to their table at the beginning of each meal. Dietary and nursing staff have been re-educated by the Director of Nursing or designee regarding Retail Food Establishment Sanitation Requirement that food is displayed under sanitary conditions including but not limited to not placing drinks on tables uncovered when the resident is not present as of 6-2-15. 4. Meal audits will be conducted by the Director of Nursing or designee to determine that food is being displayed under sanitary conditions, including that drinks are not uncovered if no resident present, weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Audits will rotate on different days of the week, including weekends, and include an observation of all 3 meals on a rotating basis. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further review. 5. Date of compliance: 6-3-15	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS			

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Bldg. 00	& BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure temperature logs were kept current in 2 of 2 medication storage rooms. (Storage room A, and Storage Room B).	F 431	**F431** 1. The temperature for the refrigerator located in medication room A and B were taken and found to be within the acceptable range	06/03/2015

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	Findings include: On 4/29/2015 at 10:45 a.m., an observation of the medication storage room B indicated there was no refrigeration log present. The temperature was 39 degrees Fahrenheit. On 4 /29/2015 at 2:00 p.m., the Refrigerator temperature monitoring log for medication room A for April 2015, indicated temperatures were missing for the 11, 12, 18, 20, and 25th of April 2015. On 5/1/2015 at 10:00 a.m., requested all temperature logs for the both medications rooms for February and March 2015. No copies of the logs were provided. On 5/1/2015, requested policy related to temperature log for medication rooms. No policies related to refrigerator temperature logs were provided. 3.1-25(m)		and documented on the temperature log on _5-24-15_by a licensed nurse.. 2. An audit of the facility was completed by a licensed nurse to determine that all refrigerator temperature logs are in place and completed as indicated. 3. Nursing staff were re-educated on Checking the temperatures of refrigerators and how to complete the temperature logs as of 6-2-15 by the Director of Nursing or designee. 4. An audit of the refrigerator temperature logs will be completed by the Director of Nursing or designee weekly x 4 weeks, every 2 weeks x8 weeks, monthly x3 months and then quarterly x6 months. The results of audits will be submitted and reviewed by the monthly Quality Assurance committee for further recommendation. 1. Date of Compliance 6-3-15	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR			

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(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
Bldg. 00	TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure housekeeping and maintenance staff maintained a sanitary, functional, and comfortable environment for 16 of 19 residents observed during stage 1 environmental tour. Findings include: On 4/27/15 at 3:15 p.m., during an environmental tour with the Housekeeping Supervisor and Maintenance Supervisor present the following was observed: 1). Room 101's pull cord for the curtain was off and lying on the window ledge. 2). Room 104's privacy curtains had small stains. 3). Room 106 had scuff marks on the wall near the bathroom. 4). Room 108's bathroom call light string was missing. The Maintenance Supervisor indicated there should be a string on the bathroom call light in room 108, and the call light was a new system.	F 465	**F465** 1. Room 101- The pull cord for the curtain was replaced on 4-29-15 by Room 104- The privacy curtains were washed on 4-29-15 by the laundry staff. Room 106- The scuff marks on the wall near the bathroom was cleaned by the housekeeping staff on 4-29-15. Room 108- The bathroom call light string was replaced by the Maintenance staff on 4-27-15. Room 110- The drapes were cleaned on 5/8/2015 and the room was deep cleaned on 5/8/2015 by the housekeeping staff. Room 111A- The walls were painted on 5/13/2015, the floor was cleaned and repaired on 5/14/2015, the face of the air conditioner was replaced on 5/13/2015 by the Maintenance and Housekeeping directors. Room 207- The privacy curtains were washed on 5/23/2015 by laundry staff.	06/03/2015

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NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429	

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	5). Room 110's drapes had stains on them. The Housekeeping Supervisor indicated that was paint. Staff had not deep cleaned in 3 weeks. The curtains are taken down and cleaned during deep cleaning. 6). Room 111 bed A had ripped paint behind the bed, multiple scuff marks on the bathroom walls. The floor was cracked in multiple places in front and underneath a recliner chair. Scuff marks on the wall behind the recliner. The face of the air conditioner was falling off and reminisce of duct tape was around the face plate. The bathroom floor was covered in brown sticky substance around the floor boards. The Maintenance Supervisor indicated, "I see what you are talking about." 7). Room 207 had dirty privacy curtains with brown substance in several spots. 8). Room 307's bathroom floor was dirty and the metal plate on the door had hanging loose metal. 9). Room 308's door handle was loose, closet door off the hinge, and a gash in the wall by the bathroom. 10). Room 309 had damaged closet door, gashes in the wall by the closet and		Room 307- The bathroom floor was cleaned on 5/25/2015 by housekeeping, and the metal plate on the door was repaired on 5/15/2015 by the Maintenance Director. Room 308- The door handle, closet door, and wall was repaired by the Maintenance Director on 5/15/2015. Room 309- The closet door and walls were repaired on 5/16/2015 by the Maintenance Director. Room 311- The wall and the bathroom plate on the door was repaired on 5/13/2015 by the Maintenance Director. Room 403- The bathroom floor was repaired and cleaned, the caulk around the toilet replaced and the drywall repaired on 5/23/2015 by the Maintenance Director. Room 404- The floor in the bathroom was cleaned and repaired on 5/27/2015 by the Maintenance Director. Room 406- The bathroom floor and the toilet were cleaned on 5/15/2015 by housekeeping staff. Room 407- The toilet was cleaned by housekeeping staff and the toilet seat repaired by Maintenance staff on 5/15/2015	

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	damaged wall behind the bed by the door and closet. 11). Room 311's walls were damaged by the bed near the door and the bathroom plate on the door was loose. 12). Room 403's bathroom floor appeared in disrepair. The bathroom floor had black stains around the toilet, caulking around the toilet had rust stain, and an small chunk of drywall was missing next to the toilet. 13). Room 404 had black stains around the toilet floor and the floor had indentations. 14). Room 406's bathroom floor had brown stains all over with stains running from the rim of the toilet to the floor and in the middle of the toilet. 15). Room 407 had black stains around the toilet base and the toilet seat was loose. 16). Room 408 had black stains around the toilet base, window curtains dirty and the closet door was off track. On 4/27/15 at 3:30 p.m., the Maintenance Supervisor indicated we are in the process of replacing all closet doors and		Room 408- The toilet and curtains were cleaned on 5/6/2015 by the Housekeeping staff. The closet door was placed on track by the Maintenance staff on 5/7/2015. 2. All remaining rooms were checked for needed repairs and the repairs were completed or scheduled with a contractor as of 6-2-2015. 3. A cleaning schedule to systematically deep clean and perform needed repairs was developed by the Administrator on 5/1/2015 to include each resident room and common area each month. The Housekeeping and Maintenance staff were re-educated to the cleaning schedule and the expectation that the facility must provide a safe, functional, environment. 4. An audit will be conducted by the Administrator or designee to determine that the deep cleaning a and repair schedule is followed as indicated weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and then quarterly for 6 months. Any concerns identified will be addressed at that time. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation.	

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	floor tile. The Maintenance Supervisor indicated there was no requisition for replacing the closet doors, but there was a proposal for replacing tile in the facility. On 4/27/15 at 4:00 p.m., the Housekeeping Supervisor indicated she was not sure when the last deep cleaning was done, but that was when they remove and clean the curtains. The Housekeeping supervisor indicated there was no current cleaning schedule available and she would make a deep cleaning schedule. On 4/28/15 at 1:36 p.m., the Maintenance Supervisor provided "Proposal description-Flooring replacement ..." dated 4/20/15. The proposal indicated proposed totals to replace flooring in the corridors, nurse station area, public restrooms, resident rooms (40), dining room, and resident lounge. On 4/30/15 at 9 00 a.m., the Administrator indicated there was no policy and procedure for cleaning and maintenance of resident's room. On 5/1/15 at 2:27 p.m., the Administrator provided policy "Resident Room [Deep Cleaning] Procedures dated 11/4/11, and indicated the policy was the one currently used by the facility. The facility policy indicated, " ... clean walls, doors, cove		5. Date of compliance:6-3-15	

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	base, ...wet mop floor, ...Be sure to remove any tape on wardrobe, walls, doors etc. ..." 3.1-19(f)			
F 999 Bldg. 00	3.1-21 FOOD (i) The facility must do the following (2) Comply with 410 IAC 7-24 This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Retail Food Establishment Sanitation Requirement manual was available to dietary staff. Findings include: On 4/30/15 at 4:00 p.m., Cook #1 was observed not to have the Retail Food Establishment Sanitation Requirement manual available for dietary staff. Cook #1 was not aware of that manual. On 4/30/15 at 4:25 p.m., Cook #1 with	F 999	**F9999** 1. The Retail Food Establishment Sanitation Requirement manual was obtained and placed in the kitchen on 5/1/2015 by the Director of Nursing. 2. The cooks (#1 & #2) received education about the appropriate temperature of cooked foods and where to find that information in the Retail Food Establishment Sanitation Requirement manual by the Dietary Manager on 4/30/2015. 3. All food services workers and cooks were re-educated about the location of the Retail Food Establishment Sanitation Requirement manual and a second copy was obtained and placed in the kitchen as of 6-2-15 by the Dietary Manager. 4. An audit will be conducted to	06/03/2015

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	the Dietician present indicated, he was not aware of the "Retail Food Establishment Sanitation Requirement" manual. Cook #1 was not aware of the regulatory requirement for ensuring accurate temperature of cooked food. On 5/1/15 at 11:50 a.m., Cook #2 indicated he was not aware of the "Retail Food Establishment Sanitation Requirement" manual. Cook #2 indicated he did not know the regulatory requirement for ensuring accurate temperature of cooked food. On 5/1/15 at 11:30 a.m., the Director of Nursing indicated, there was no Retail Food Establishment Sanitation Requirement manual available at that time.		determine that the Retail Food Establishment Sanitation Requirement manual is available to staff by the Dietary Manager or designee weekly for 4 weeks, every 2 weeks for 8 weeks, monthly for 3 months and the quarterly for 6 months. The results of the audits will be submitted and reviewed by the monthly Quality Assurance Committee for further recommendation. 5. Date of compliance:6-3-15	