STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00350711. Complaint IN00350711 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F684, and F692. Survey dates: May 2, 3, 4, 5, and 6, 2021 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 3 Medicaid: 29 Other: 4 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/10/21.	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance effective June 5, 2021 to the annual survey conducted on May 2-6, 2021 and request paper compliance.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.			
	Based on record review and interview, the facility failed to provide a copy of the Bed Hold policy and Notice of Transfer or Discharge to a resident's POA (power of attorney) for 1 of 2 residents reviewed for hospitalization. (Resident 15) Finding includes: The record for Resident 15 was reviewed on 5/3/21. The resident's diagnoses included, but were not limited to, Diabetes Mellitus, heart failure, and delusional disorder. The Quarterly Minimum Data Set assessment, dated 2/20/21, indicated the resident was not cognitively intact. Nursing Progress Notes indicated the resident	F 0625	**F625 Notice of Bed Hold Policy Before/Upon Transfer** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *Resident 15 returned to the facility prior to the survey being conducted. Therefore, a notice could not be sent. The resident was not harmed by the alleged deficient practice.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action*	06/05/2021

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	had a change in mental status on 1/29/21 and was sent to the hospital for evaluation. She was admitted to the hospital and returned to the facility on 2/3/21. The Notice of Transfer or Discharge had been partially completed to include the resident's name, date of transfer and facility transferring from. The remainder of the form was not completed. The form indicated, "...the facility must attach a copy of the facility's bed hold policy to this Notice of Transfer or Discharge and provide contact information for a facility employee to contact about the bed hold policy...." There was no indication the resident's POA had received a copy of these documents. During an interview with the Director of Nursing on 5/4/21 at 2:45 p.m., indicated she was not aware the POA was to be provided copy of the documents, but indicated they would start doing so. 3.1-12(a)(25) 3.1-12(a)(26)		*will be taken?* On May 19, 2021 a facility wide audit was conducted by the Administrator to determine if there were any residents at the hospital whose responsible party did not receive the transfer/discharge notice and bed hold policy. All residents were in the facility. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *Social Service designee received an inservice on the Transfer/Discharge Notification process.* *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* *A Performance Improvement Tool has been initiated that will check the facility roster for transfers/discharges weekly times three (3) months then bi-weekly times 3 months to ensure that the proper notification of the transfer/discharge has been given to the responsible party. The audit will be conducted by Social Service Designee/Designee. In the event a deficiency is identified, it will immediately be corrected. This will be tracked in an ongoing tracking log.* Above audit tool to be reviewed at least quarterly, or as needed, in QA meeting. *By what date the systemic*	

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			changes will be completed? 6/5/21	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a dependent resident related to unclean and untrimmed fingernails for 1 of 3 residents reviewed for activities of daily living. (Resident C) Finding includes: On 5/2/21 at 12:15 p.m., Resident C was observed sitting up in bed having lunch. The resident's fingernails were long with dark debris underneath them. On 5/3/21 at 1:37 p.m., Resident C was observed lying in bed with his eyes closed. The resident's fingernails were long with dark debris underneath them. On 5/4/21 at 8:32 a.m., Resident C was observed lying in bed with eyes closed. The resident's fingernails were long with dark debris underneath them. On 5/5/21 at 9:10 a.m., Resident C was observed lying in bed with his eyes open. The resident's fingernails were long with dark debris underneath them. Interview with the resident at the time indicated he needed his nails cut but he couldn't find his nail clippers.	F 0677	F 677 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Upon surveyor observation nail care was immediately provided to resident C. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents have the potential to be affected by this alleged practice. All residents' nails were inspected and any deficiencies identified were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Nursing employees will be in-serviced on the provision of ADL's. ADL's will be monitored and audited to ensure that each resident is receiving the necessary	06/05/2021

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	On 5/6/21 at 11:28 a.m., Resident C was observed lying in bed with his eyes closed. The resident's fingernails were still long with dark debris underneath them. Record review for Resident C was completed on 5/4/21 at 1:58 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, malnutrition, and schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/21, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist with bed mobility, transfers, and toilet use. He required an extensive 1 person assist with hygiene, and a total 1 person assist with bathing. A Care Plan indicated the resident had an ADL (activities of daily living) Self Care Performance Deficit related to limited mobility. Interventions included to have staff assistance as needed for bathing and personal hygiene. Interview with CNA 1 on 5/6/21 at 11:30 a.m., indicated she had given the resident a bed bath that morning and must have missed cleaning his nails. She would go back and check his fingernails to cut and clean them. This Federal Tag relates to Complaint IN00350711. 3.1-38(a)(3)(E)		care and services. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks three (3) residents to ensure that ADL care has been provided.This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee three (3) times a week for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting monthly. ***By what date the systemic changes will be made;*** 6/5/2021	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment and services related to not completing laboratory work as ordered by the physician for 1 of 2 residents reviewed for hospitalization. The facility also failed to ensure a resident's skin discoloration was assessed and monitored for 1 of 4 residents reviewed for non-pressure related skin conditions. (Residents B and 5) Findings include: 1. Closed Record review for Resident B was completed on 5/3/21 at 2:08 p.m. Diagnoses included, but were not limited to, pneumonia, malnutrition, dementia, and Alzheimer's disease. The Admission Minimum Data Set (MDS) assessment, dated 12/8/20, indicated the resident was severely cognitively impaired. A Nursing Note, dated 3/8/21 at 11:39 a.m., indicated the resident had a dry, non-productive cough. The resident's Nurse Practitioner was in the facility and saw the resident. New orders received were for a chest x-ray and labs to be completed. A Nursing Note, dated 3/9/21 at 2:44 p.m., indicated the resident's chest x-ray results involved an acute infiltrate in the right lung (associated with pneumonia).	F 0684	F684 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** The facility in unable to retrospectively correct the surveyor concern in regards to Resident B. Upon surveyor observation the bruise to Resident #5's left hand was assessed and an incident report was generated. The Physician and the Responsible Party were notified. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents have the potential to be affected by this alleged practice. A chart was completed and all residents with orders for non-routine labs were identified. It was then verified that each non-routine lab order had a requisition in place for the lab draw to be completed. All residents have the potential to be affected by this alleged practice. A facility wide skin	06/05/2021

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	A Nursing Note, dated 3/13/21 at 11:00 p.m., indicated a CNA taking care of the resident stated the resident "just isn't acting right and not responding like normal". The resident's vitals were taken. The resident's respirations were elevated to 60, Blood Pressure was 89/52, Pulse 107, Temperature 89.7 F, and oxygen saturation on room air was 85%. Oxygen was applied to the resident via a nasal cannula. The Physician was paged and informed of the resident's change in condition. The physician ordered to start IV (intravenous) fluids. The nurse re-paged the Physician after 4 attempts to start the IV site without success. The Physician ordered for the resident to be sent to the Emergency Room. A Nursing Note, dated 3/14/21 at 6:04 a.m., indicated the resident was admitted to the hospital with diagnoses of sepsis and acute respiratory failure. The Physician's Order Summary (POS), dated March 2021, indicated an order to complete laboratory work of a CBC (complete blood count), and BMP (basic metabolic panel). The labs were ordered on 3/8/21 and to be completed on 3/10/21. The record lacked any documentation the laboratory work the Physician ordered to be completed on 3/10/21 had been done. Interview with the Director of Nursing on 5/4/21 at 1:40 p.m., indicated the residents laboratory work was not completed as ordered. 2. On 5/2/21 at 11:33 a.m. Resident 5 was observed seated in her wheelchair in her room watching television. There was a dark purple/blue discoloration to top of her left hand near her 4th/5th knuckles. The resident did not know how she obtained the discoloration		check was completed and any newly identified areas of bruising were addressed. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Licensed Professional Staff will be provided in-servicing regarding the process to follow when receiving an order for any non-routine labs. An audit will be completed to ensure that labs are being completed as ordered by the physician. Nursing employees will be in-serviced on the importance of timely identification/documentation of newly identified skin issues. An audit will be completed to ensure that any newly identified skin issues are assessed and documented in the resident's medical record. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that will check new non-routine lab orders to ensure completion. A Performance Improvement Tool has been initiated that randomly checks three (3) residents for any new skin integrity issues. Both Quality Assurance Audit Tools will be completed by the Director of Nursing/Designee three	

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	or how long it had been there. On 5/4/21 at 10:19 a.m. the resident was seated in her wheelchair in her room. The purple discoloration was observed to the top of her left hand. On 5/6/21 at 9:45 a.m. the resident was seated in her wheelchair in her room. The purple discoloration was observed to the top of her left hand. Interview with LPN 2 on 5/6/21 at 9:53 a.m., indicated she was unaware the resident had a discoloration to her left hand. She then proceeded to go into the resident's room to assess the discoloration. She indicated the resident had a blood draw this week and last week and they probably used her hand. She would document the area. Record review for Resident 5 was completed on 5/5/21 at 10:16 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and congestive heart failure. The Quarterly MDS assessment, dated 2/4/21, indicated the resident was cognitively impaired. The resident required an extensive 2 + person assist for dressing, personal hygiene, toilet use, and transfers. The resident had received anticoagulant (blood thinning) medication. A Care Plan indicated the resident was taking anticoagulant medication related to atrial fibrillation. An intervention included to monitor, document, and report any adverse reactions of anticoagulant therapy which included bruising. A Care Plan indicated risk for skin breakdown. An		(3) times a week for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting monthly. ***By what date the systemic changes will be made;*** 6/5/2021	

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	intervention included, "... observe skin during care and with each encounter for evidence of breakdown, notify nurse should skin problem be noticed (bruising, skin tear, pressure area etc.) ..." The Physician's Order Summary (POS), dated May 2021, indicated an order for apixaban (Eliquis, a blood thinning medication) 2.5 mg (milligrams) twice a day for atrial fibrillation. The most recent weekly skin review, dated 4/30/21, indicated the resident's skin was intact. There were no areas of bruising or discoloration documented. A facility policy, titled "Incidents-Bruising," received from the Director of Nursing as current, indicated "...2. An identified bruise will be measured. This measurement will be noted on the incident report and in the clinical record..." This Federal tag relates to Complaint IN00350711. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates			

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	that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review and interview, the facility failed to provide adequate hydration to a dependent resident for 1 of 1 residents reviewed for hydration. (Resident E) Finding includes: Resident E was observed seated in her room on 5/2/21 at 11:35 a.m. and 2:30 p.m., there were no beverages in the room or in reach of the resident. During continuous observation on on 5/4/21 from 8:30 a.m. to 11:10 a.m.. there was no beverage in the resident's room or in reach of the resident. No staff member entered the room during that time and offered fluids. The resident's record was reviewed on 5/3/21 at 12:50 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's, dementia and anxiety. The Minimum Data Set Significant Change assessment, dated 3/30/21, indicated the resident needed extensive one person assistance for eating, and was not cognitively intact. The resident's lab results on 8/12/20, 10/7/20, 4/7/21 and 4/14/21, indicated an elevated BUN (blood urea nitrogen, a kidney function indicator). On 8/12/20 and 10/7/20, the Nurse Practitioner ordered to encourage fluids.	F 0692	F 692 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident E is receiving fluid monitoring in accordance with the physician's order. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents have been reviewed and are receiving services in accordance with the plan of care related to hydration. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The nurses have been in-serviced related to assuring that residents receive services in accordance with the physician's order. The in-service included assuring that hydration intake is offered appropriately for those residents that they identify to have poor	06/05/2021

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	On 4/7/21, the Nurse Practitioner ordered to offer 4 ounces of fluids every hour while the resident was awake, and to repeat labs in one week. The CNA assignment sheet indicated to pass fresh ice water to every resident each shift. It indicated the resident needed assistance to eat, but did not specify to give water hourly or to encourage fluids. Interview with LPN 1 on 5/4/21 at 11:10 a.m., indicated it was the nurses and CNA responsibility to give the resident water. She indicated there was no water in the resident's room because she was unable to hold on to it and drink by herself. She gave the resident 4 ounces of water at that time, which she drank entirely. This Federal tag relates to Complaint IN00350711. 3.1-46(b)		intake or have any indicators of adequate hydration issues. The IDT will also be actively involved with assuring that any resident that has hydration issues is monitored adequately in accordance with the plan of care. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly reviews five (5) residents related to hydration encouragement in accordance with the physician's orders. The Quality Assurance Audit Tools will be completed by the Director of Nursing/Designee three (3) times a week for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting monthly. ***By what date the systemic changes will be made;*** 6/5/2021	
F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, record review and	F 0912	**F912 Bedrooms Measure at**	06/05/2021

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interview, the facility failed to provide a least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208)

Findings include:

1. The floor area of the following single resident room measured:
a. Room 111-1 resident, 96.2 SQ FT. NF.

2. The floor areas of the following multiple resident rooms measured:
a. Room 101 - 1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF.
b. Room 104 - 1 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF.
c. Room 201 - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF.
d. Room 202 -2 beds, 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF.
e. Room 204 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF.
f. Room 206 - 1 resident, 140.0 SQ FT, 70.5 SQ FT per bed. NF.
g. Room 208 - 1 residents, 146.9 SQ FT, 73.4 SQ FT per bed. NF.

The facility rooms with room variances were observed on 5/5/21 at 11:50 a.m. The rooms were observed with the following number of beds:
Room 101 - 1 bed
Room 104 - 1 bed
Room 111 - 1 bed
Room 201 - 1 bed
Room 202 - 2 beds
Room 204 - 1 bed
Room 206 - 1 bed

Least 80 Sq/Ft/Resident
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
/i>
How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
/i>
What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?
/i>
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
/i>
By what date the systemic changes will be completed?
06/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Room 208 - 1 bed Interview with the Administrator on 5/6/21 at 11:20 a.m., indicated these were the rooms which had the variance waivers and there had not been any changes from the previous annual survey. 3.1-19(l)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional, safe, and homelike environment related to missing heater covers, holes in doors and walls, water-stained ceiling tiles, plaster patches, loose outlet, chipped paint and marred walls for 7 of 30 resident rooms. (Rooms 104, 110, 112, 118, 123, 126 and 202) Findings include: During the Environmental Tour on 5/4/21 from 1:37 p.m.-1:55 p.m. with the Maintenance Supervisor, the following was observed: 1. First floor: a. In Room 104, the heater cover was off and laying on the floor, there were two water stains on the ceiling tiles and the wall by the sink was chipped and marred. There was one resident who resided in this room. b. In Room 110, the heater cover was bent and falling off, there was a hole in the wall where the wall cover was missing for the cable cord, and the	F 0921	**F921 Safe/Functional/Comfortable Environment** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *No residents were harmed by the alleged deficient practice. All room locations cited will have repairs done to the identified room.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* *The Director of Maintenance will complete an inspection of all other rooms in the building and correct any deficiencies that were identified.* *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?*	06/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/06/2021

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	walls by the closet were chipped and marred. There were two residents who resided in this room. c. In Room 112, the corner by the door was chipped and marred. There was one resident who resided in this room. d. In Room 118, there was a doorknob sized hole on the outside bathroom door, an outlet was loose and pulling away from the wall, and marred walls were noted. One resident resided in this room. e. In Room 123, there were white plaster patches on the door. Two residents resided in this room. d. In Room 126, there was a white plaster patched on wall near the door and another above the bed. One resident resided in this room 2. Second floor: a. In Room 202, there were gouges on the wall by the bed. One resident resided in this room. Interview with the Maintenance Supervisor at the end of the tour, indicated the above was in need of repair. 3.1-19(f)		*Staff received an inservice on completing work orders when problem areas are identified. The Director of Maintenance received an inservice on preventative maintenance and identifying problems in/around the facility.* *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* *A Performance Improvement Tool has been initiated that randomly checks 5 resident rooms for any environmental issues. The QA Audit Tool will be completed by the Director of Maintenance or designee weekly for three (3) months and bi-weekly for 3 months. Any deficiencies found will be immediately corrected.* Above audit tool to be reviewed quarterly or as needed in to QA meetings *By what date the systemic changes will be completed?* June 5, 2021	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:	F 9999	**F9999** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *The identified employees*	06/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/06/2021

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(1) Residents' rights.

(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:

(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

This rule is not met as evidenced by:

Based on record review and interview, the facility failed to ensure each employee received the required yearly training for Resident Rights, Abuse and Dementia for 4 of 10 employees reviewed. (LPN 1, CNA 2, RN 1, and Laundry Assistant 1)

Findings include:

The employee records were reviewed on 5/5/21 at 1:08 p.m., and indicated the following:

a. LPN 1, hired on 9/1/11, had no resident rights training completed in 2020.

b. CNA 2, hired on 7/20/17, had no resident rights training completed in 2020.

completed Resident Rights for the current year.
How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
/i>
What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?
/i>
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
/i>
By what date the systemic changes will be completed?
6/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/06/2021

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	c. RN 1, hired on 4/14/16, had no resident rights training completed in 2020. d. Laundry Assistant 1, hired on 3/22/19, had no resident rights, abuse, or dementia training completed in 2020. Interview with the Business Office Manager on 5/5/21 at 1:55 p.m., indicated the above staff did not complete the required yearly inservices.			