STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155786		08/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit inlcuded the Investigations of Complaints IN00176650 and IN00175716. This visit was in conjunction with the Investigation of Complaint IN00179129. Complaint IN00176650 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F157. Complaint IN00175716 - Substantiated. Federal/State deficiencies related to the allegations are cited at F242. Survey dates: July 29, 30, 31, August 3, 4, 5, 6, and 7, 2015 Facility number: 0012466 Provider number: 155786 AIM number: 201014060 Census bed type: SNF: 30 SNF/NF: 115 Total: 145 Census payor type: Medicare: 30 Medicaid: 91	F 0000	F0000, The creation and submission of the Plan of correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of correction be considered the letter of credible allegation and request a post survey visit on or after Sept 6,2015	

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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	Private: 23 Other: 1 Total: 145 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
F 0157 SS=G Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.			

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	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to timely notify a resident's physician of her inability to take her medications and notify of her medical symptoms resulting in delayed hospitalization for 1 of 1 resident reviewed for hospitalization. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 8/5/15 at 2:00 p.m. The diagnoses for Resident #D included, but were not limited to: history of stroke and hypertension. The 3/09/2015, 5:30 p.m. nurses note indicated, "Resident's BP (blood pressure) was assessed by the dinning room 234/117(bp). Writer assisted resident to bed for further assessment. Will continue to monitor." This nurse's note was written by RN #12. The 3/9/15, 5:30 p.m. nurse's note indicated, "Writer in dining room for meal service, res.(resident) able to communicate with staff members without difficulty. As meals were being served, writer noted resident to be leaning	F 0157	**F0157 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There is no corrective action for resident # D as she no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** All residents having a condition change in status will be assessed by licensed nurse and Physician will be notified in a timely manner of the condition change. Nursing staff educated/in serviced on the importance of recognizing condition status change in residents of the facility, timely documentation, timely notification to Physician for orders, accurate information relayed to the Physician for orders, and family member notification. DNS/designee will be notified of all resident condition changes. DNS/designee will run facility report to audit documentation on routine basis. Education will continue to be given to licensed nursing staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	09/04/2015

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	slightly to the right side of her chair and was beginning to lay her head on the table. Writer asked resident if she was feeling okay, resident continued to look at writer with no verbal response. Vitals assessed, BP (blood pressure) elevated, all other vitals WNL (within normal limits). Small amount of emesis noted to pant leg. Resident then removed from the dining and taken to 400 nurse for review of status and orders. Slight facial drooping noted to right side of face, face flushed, right side of body rigid. Resident began to have difficulty sitting upright, writer and 400 hall nurse assisted resident into bed, where large amounts of emesis occurred. Reviewed code status and nurse began contacting (name of doctor's office) and daughter for orders and notification. Res. resting in bed with eyes closed at this time while obtaining orders from MD. Awaiting new orders at this time." This nursing note was recorded as a late entry on 3/10/15 at 3:19 p.m. by RN #11. The 3/9/15, 5:55 p.m. nurse's note indicated, "Resident was laid down in bed, notified (name of physician's office) of elevated BP and spoke to (name of physician call center staffperson) for possible orders. (Name of physician's office) said writer should give her PRN (as needed) Zofran (anti-nausea medication) and the wait for thirty		Education/In service for licensed nurses will be completed by 8/28/15 for condition changes, SBAR, Physician notification, family notification, documentation accuracy, and documentation. Licensed staff will communicate changes to DNS/designee of condition changes on residents. Unit managers/designee will review nursing documentation routinely for condition changes and appropriateness of documentation. Licensed nurses educated on 8/17/15 & 8/20/15. Re education will be given if needed up to disciplinary action by DNS/designee. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** CQI tool for Condition changes/Assessments will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters.· The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	minutes to give the antihypertensive medication." This note was recorded as a late entry on 3/11/15 at 1:49 p.m. by RN #12. The 3/9/15, 6:20 p.m. nurse's note indicated, "Writer attempted to give resident medication (Zofran) crushed in apple sauce as ordered. Resident took medications in her mouth but refused to swallow and spit them on the floor. Will continue to try to offer." This note was recorded as a late entry on 3/11/15 at 1:56 p.m. by RN #12. The 3/9/15, 6:30 p.m. nurse's note indicated, "Writer tried to give resident the PRN medications Zofran crushed in apple sauce again and resident spit them out. Resident's BP at this time was 154/127. Will continue to offer medication and monitor BP. This note was recorded as late entry on 3/11/15 at 2:00 p.m. by RN #12. The 3/9/15, 6:40 p.m. nurse's note indicated, "Writer called AHA again told them that resident spit out medication Zofran and HTN, AHA said try to give just Zofran and then HTN (hypertension) medication and observe if she will be able to swallow. Resident spit them out again. At this time resident was tearful, diaphoretic, and pale. Will continue to monitor for elevated BP." This note was recorded as a late entry on 3/11/15 at 2:08 p.m. by RN #12.			

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	The 3/9/15, 7:20 p.m. nurse's note indicated, "Approx. (Approximately) 7:20pm nurse on 400 hall asked this writer to come to room to assess resident and attempt to give PRN medications. This nurse attempted to give these meds crushed in applesauce to resident. Res was unable to swallow and spit the medications out. Writer assessed BP and results were 221/87. Writer noted that resident was becoming diaphoretic and flushed. Res has no s/s (signs/symptoms) of facial drooping or one sided weakness. Writer spoke w/400 hall nurse and it was decided that it would be best to call (name of physician's office) and 911 and send her to ER for eval (evaluation) r/t (related to) resident's wishes as documented in her POST form. This note was recorded as a late entry on 3/10/15, at 1:12 p.m. by RN #13. The 3/9/15, 7:30 p.m. nurse's note indicated, "Writer got another nurse to attempt (sic) administer Amlodipine and Zofran medication but resident refused from that nurse as well. At this time resident BP was 221/87. Resident was diaphoretic. Both nurse and writer agreed that resident needed to be sent out to ER. Will continue to monitor for elevated BP. This note was recorded as a late entry on 3/11/15, at 2:24 p.m. by RN #12. The 3/9/15 7:35 p.m. nurse's note indicated, "CNA (Certified Nursing			

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	Assistant) was providing care to resident ready to be sent out. Will continue to monitor for elevated V/S (vital signs). This note was recorded as a late entry on 3/11/15 at 2:34 p.m. by RN #12. The 3/9/15, 7:40 p.m. nurse's note indicated, "(Name of physician's office) was called and spoke to Angel who gave order to send her out. 911 was called immediately. Writer tried to call daughter numerous times and left message but did not speak to her. Tried to call daughter's work but co worker stated that she was not there at that time. EMTs arrived at approx. 7:50pm. While EMTs were assessing resident, res daughter called back and asked if there was anything that could be done in house instead of sending resident to hospital. Daughter specifically asked if facility had IM Lopressor to administer. Writer went to facility EDK (emergency drug kit) and checked for IM Lopressor but noted that there was only tablets. At that time daughter stated it was ok to send resident out. This note was recorded as a late entry on 3/11/15 at 2:30 p.m. by RN #13. The 3/9/15, 7:50 p.m. nurse's note indicated, "EMT arrived at this time. Resident transferred to (name of hospital) ER via stretcher. Report was called to ER nurse. This note was recorded as a late entry on 3/11/15 at 2:58 p.m. by RN #12.			

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	The 3/9/15, 11:00 p.m. nurse's note indicated, "Staff called (name of hospital) @ 11 pm to find out how she was doing. Nurse reported that she was admitted for possible stroke. This note was recorded as a late entry on 3/10/15 at 12:30 p.m. by RN #12. An interview was conducted with RN #13 on 8/5/15 at 1:08 p.m. She indicated, after 7:00 p.m., RN #12 asked her if she would help give medications to Resident #D. She indicated she hadn't seen Resident #D all day, and didn't know what was going on with her. She indicated she assessed Resident #D, who was "kind of rocking" in her bed. She indicated Resident #D was holding onto the side rail of her bed, was getting really sweaty, wouldn't talk and usually did. She indicated she didn't notice Resident #D leaning to the right side or facial drooping. She indicated Resident #D gripped her hands during assessment. She indicated she assessed her for stroke because she knew her blood pressure was high. She indicated during her assessment she checked her vitals, heart sounds, looked at her face, arms, and legs, turned her to the sides, and palpated her abdomen. She indicated Resident #D's blood pressure was so high, she didn't want to waste any time, and felt more comfortable calling 911.			

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	RN #11 and RN #12 no longer worked at the facility and were unavailable for interview. A telephone interview was conducted with the physician's office call center supervisor on 8/4/15 at 1:44 p.m. She indicated there were a total of 3 telephone calls from the facility to the call center on 3/9/15, regarding Resident #D. She indicated the facility informed of vomiting and trouble with blood pressure, but no information on right sided facial drooping or being nonverbal. She indicated Resident #D was sent to the hospital at the last phone call, at 7:34 p.m. Three transcribed telephone conversations from 3/9/15 were provided by the physician's office call center on 8/7/15 at 2:20 p.m. The times were 5:46 p.m., 5:50 p.m., and 7:34 p.m. There was no telephone conversation at 6:40 p.m. as indicated in the 3/9/15, 6:40 p.m. nurses note. None of the 3 conversations referenced the 3/9/15, 5:30 p.m. nurse's notes symptoms of leaning to the right side, laying her head on the table, no verbal response, slight right side facial drooping, face flushed, right side body rigidity, or difficulty sitting upright. The 5:46 p.m. conversation between the			

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	physician's call center and the facility was made by RN #12. It included orders for 12.5 mg of Phenergan (anti-nausea medication) and to reattempt blood pressure medicine "1/2 hour afterwards". The 5:50 p.m. conversation was made by RN #12 to inform of Resident #D's current order for Zofran. The call center indicated, "So you can go ahead and give her the Zofran" instead of the Phenergan. The 7:34 p.m. phone conversation was made by RN #13. It indicated, "I have a resident who...um...her blood pressure is 216/157 and we can't get her to swallow any pills to get her...uh...I know my associate had called earlier...um....so we kind of really want to send her out. I just need the ok from you guys." There were no calls made between 5:50 p.m. and 7:34 p.m. to inform the physician of Resident #D's inability to swallow her anti-nausea and blood pressure medication. An interview was conducted with the DON (Director of Nursing) on 8/6/15 at 10:24 a.m. She indicated she was at the facility on 3/9/15, when Resident #D was in the dining room, but she did not see her in there. She indicated it was common for her to have episodes of high blood pressure, to vomit, and to be difficult to arouse. She indicated she			

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	couldn't determine whether nursing staff acted appropriately to Resident #D's medical symptoms. She indicated if she (DON) saw the symptoms RN #11 documented in her nurse's note and considered Resident #D "really different from normal", she would have informed the physician. She indicated she "possibly" would have expected the physician to be notified of right sided body rigidity, right sided facial drooping, and being nonverbal. She indicated she would have expected RN #12 to call the physician's office back 20-30 minutes after the order for antinausea medication to inform them of Resident #D's inability to swallow her blood pressure medication. She indicated she saw Resident #D briefly in the hallway and didn't see any right sided facial drooping. The 3/9/15 Department of Fire and Emergency Patient Care Record for Resident #D's transportation to the hospital indicated they received the call at 7:38 p.m., were on the scene at 7:44 p.m., at the patient at 7:46 p.m., and at the hospital at 8:07 p.m. It indicated, "BP-216/157, s/s-neurological stroke symptoms w/weakness/paralysis, protocol used-suspected stroke, primary impression-stroke/cva (cerebral vascular accident), duration-3 hours, barriers of care-altered mental status, skin-bilateral			

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	forearms and hands were red with piticii (sic), asst (assessment) time:...were dispatched to ecf (extended care facility) on increased bp. u/a (upon arrival) found (age, race, and gender of Resident #D) lying supine in bed in care of (name of) crew. Crew stated pt was in dining room around 1700 hours for dinner and staff noticed that she was slumped over to the right side and that she had right sided facial droop. Pt was awake but not alert with obvious right sided facial droop and pt's forearms and hands bilaterally where (sic) red with what appeared to be piticii (sic). pt was unable to answer any questions and attempted to pull away from vitals being taken. Unknown reason for two and a half hour delay in contacting 911. Vitals obtained and pt was hypertensive. Loaded to cot, covered, secured, amd moved to...20 g (gauge) IV to left AC (antecubital-inner elbow) was attempted but unsuccessful. 20 g IV right hand with lock established, dex (dextrose) 137 mgdl (milligrams per deciliter). 12-lead NSR (normal sinus rhythm). Transport to (name of hospital) started. Pupils were reactve but sluggish. Vitals repeated and bp increased. Radio report to (name of hospital) with stroke alert called and we were assigned (room #). Pt condition monitored and comfort measures taken. Bruising noted to pt chest and inside of right thigh. u/a report			

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	given and care turned over...." An interview was conducted with NP (Nurse Practitioner) #14, from Resident #D's physician's office, on 8/5/15 at 11:05 p.m. He indicated he remembered Resident #D, and that she had uncontrolled hypertension. He indicated if he was given the information in RN #11's 3/9/15, 5:30 p.m. nurse's note, "I would have sent her out right away. I know this patient, and those are classic symptoms of stroke and cardiovascular issues. I would have sent any patient out with those symptoms right away." The 3/9/15, 8:16 pm emergency room hospital records indicated, "Patient presents with Possible CODE STROKE pt slumped over to right with right sided weakness. The history is provided by the nursing home and the EMS (emergency medical staff) personnel...Pt was evaluated by provider at 20:17 (8:17 p.m.)...presents to the ED (emergency department) with right sided facial droop x 1700. Per EMS, pt was seen in the nursing home at dinner with a facial droop. Per pt's daughter pt has a hx (history) of CVA. Pt's (family member) sts (states)the pt has a hx of weakness and uncoordination... Neurological: positive for facial asymmetry			

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	Physical exam: Pupils pin point and to slight left...No response to verbal stimuli. Mild reflexive grip but not on command...Petechiae noted...Scattered petechiae rash on the hands and some old ecchymosis. Radiology Results: Impression: large intracerebral hematoma the left basal ganglia with extension into the ventricular system. Assessment/Plan: Extensive acute intracerebral hemorrhage-CT showed intracerebral hematoma the left basal ganglia. ED discussed with neurosurgery who believe pt is inoperable. Comfort care. Morphine drip, Ativan prn (as needed). Pt is comatose...." The hospital records further indicated Resident #D died on 3/10/15 at 10:30am. An interview was conducted with Family Member #10, Resident #D's POA (power of attorney) on 8/7/15 at 3:34 p.m. She indicated she didn't understand why the facility waited so long to call 911. She indicated the first time she was contacted by the facility on 3/9/15 was approximately 7:40 p.m. She indicated she had no idea Resident #D was unconscious. This federal tag relates to Complaint #IN00176650.			

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	155786		08/07/2015

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	3.1-5(a)(2)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to provide a resident showers as preferenced for 1 of 3 residents reviewed of 5 who met the criteria for choices. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 7/30/15, at 10:30 a.m. The diagnoses for Resident #B included, but were not limited to, anxiety, depression, congestive heart failure and atrial fibrillation. During an interview with Resident #B, on 7/29/15 at 2:51 p.m., Resident #B indicated she was not receiving 2 showers a week as she preferred. On 8/4/15, at 9:39 a.m., Resident #B	F 0242	**F0242 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility will ensure that resident #B will receive showers up 2 times per week per her preference/choices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. All nursing staff educated on the importance of resident self preferences/participation in care. Education on importance of showers being completed, documentation of shower completion, and skin assessments with showers/bathing. Educated on the resident preference assessment that is completed upon admit, quarterly, annually, and with significant changes. All residents	09/04/2015

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	indicated again her preference was for 2 showers a week and she never requested any other type of full body bathing, as her preference for bathing was a shower. The MDS (minimum data set) assessment, dated 7/14/15, indicated Resident #B had a BIMS score of 14, which was indicative of cognitively intact. At 10:00 a.m., on 8/4/15, Unit Manager #1 provided Resident #B's bath/shower sheets for June and July. The Unit Manager #1 indicated the facility used a computer tracking system and a paper system to track a Resident's bathing. The June Shower Reports and the Point of Care ADL Report indicated the following full body bathing: 6/2/15-bed bath 6/4/15-bed bath 6/5/15-bed bath 6/6/15-bed bath 6/7/15-bed bath 6/8/15-shower 6/9/15-bed bath 6/12/15-shower 6/14/15-bed bath 6/16/15-bed bath 6/18/15-bed bath 6/19/15-shower 6/23/15-shower		were interviewed by Customer Care Representative to ensure other residents are receiving showers per their preference. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for nursing staff will be complete by 8/28/15 on preferences/choices/dignity issues with showers/bathing and skin assessments. Education held on 8/87/15 & 8/20/15. Unit managers/designee will review shower sheets for residents scheduled to have shower completed on daily basis. Re education will be given if needed to staff up to disciplinary action if procedure is not followed. If resident refuses/misses a shower, the unit manager/designee will ask resident if they would like a shower on a different day or time. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** CQI tool for Accommodation of needs/showers will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters.· The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved,	

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	6/26/15-shower. The July Shower Reports and the Point of Care ADL Report indicated the following full body bathing: 7/2/15-shower 7/6/15-shower 7/11/15-bed bath 7/12/15-bed bath 7/14/15-bed bath 7/16/15-bed bath 7/17/15-no care selected [Shower Report] 7/21/15-shower 7/31/15-shampoo [Shower Report]. On 8/4/15 at 11:28 a.m., RN #2 indicated she did not recall any type of refusals of bathing for Resident #B. At 11:50 a.m., on 8/4/15, the Director of Nursing indicated the facility staff should honor a resident's preference for bathing. A Preference for Daily Customary Routines for Resident #B, dated 7/14/15, indicated, "Bathing Routines Do you have a preference as to what time or how often you bathe-yes [was checked]; If Yes, please indicate resident's preferred time/frequency to bathe-2 [symbol for times] a week [was written]. What type of bathing are you used to...shower [was checked]....How important is it for you to choose between a tub bath, shower, bed		an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	bath or sponge bath-very important [was checked]...." An ADL (activities of daily living) Care Plan, dated 6/1/13 and remained current at time of review, indicated the interventions, "Rec's [Receives] shower 2 days per week....Provide shower two times per week, partial bath in between." A policy titled, Preferences for Daily Routines, dated 11/2011, was received form the Director of Nursing on 8/4/15 at 2:47 p.m. The policy indicated, " Purpose: To identify and develop a plan of care that reflects a resident's past and current daily customary routines. The Preferences for Daily Customary Routines is a tool that can be used to gather information about a resident and incorporate this into the interdisciplinary plan of care....3. The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences....4. The worksheet can be kept in an area that can be accessed by staff in order to better facilitate getting to know and accommodate resident preferences...." This Federal tag relates to Complaint IN00175716.			

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	3.1-3(u)(1)			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to recognize and address a resident's skin condition for 1 of 1 resident reviewed for skin conditions and to timely address a resident's medical symptoms resulting in delayed hospitalization for 1 of 1 resident reviewed for hospitalization. (Resident #D) Findings include: 1. a) The clinical record for Resident #D was reviewed on 8/5/15 at 2:00 p.m. The diagnoses for Resident #D included, but were not limited to: history of stroke and hypertension. The 3/09/2015, 5:30 p.m. nurses note indicated, "Resident's BP (blood pressure) was assessed by the dinning room 234/117(bp). Writer assisted resident to bed for further assessment. Will continue to monitor." This nurse's	F 0309	**F0309 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There is no corrective action for resident # D as she no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** All residents having a condition change in status will be assessed by licensed nurse and Physician will be notified in a timely manner of the condition change. All residents noted with new skin condition will be assessed, Physician notified, and treatment obtained if/as needed. Nursing staff educated/in serviced on the importance of recognizing condition status change in residents of the facility, timely documentation, timely notification to Physician for orders, accurate information relayed to the Physician	09/04/2015

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	note was written by RN #12. The 3/9/15, 5:30 p.m. nurse's note indicated, "Writer in dining room for meal service, res.(resident) able to communicate with staff members without difficulty. As meals were being served, writer noted resident to be leaning slightly to the right side of her chair and was beginning to lay her head on the table. Writer asked resident if she was feeling okay, resident continued to look at writer with no verbal response. Vitals assessed, BP (blood pressure) elevated, all other vitals WNL (within normal limits). Small amount of emesis noted to pant leg. Resident then removed from the dining and taken to 400 nurse for review of status and orders. Slight facial drooping noted to right side of face, face flushed, right side of body rigid. Resident began to have difficulty sitting upright, writer and 400 hall nurse assisted resident into bed, where large amounts of emesis occurred. Reviewed code status and nurse began contacting (name of doctor's office) and daughter for orders and notification. Res. resting in bed with eyes closed at this time while obtaining orders from MD. Awaiting new orders at this time." This nursing note was recorded as a late entry on 3/10/15 at 3:19 p.m. by RN #11.		for orders, importance of skin assessment, documentation of skin assessment, and family member notification. DNS/designee will be notified of all resident condition changes/new skin changes. DNS/designee will run facility report to audit documentation on resident changes/skin issues on routine basis. Education will continue to be given to licensed nursing staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for licensed nurses will be completed by 8/28/15 for condition changes, SBAR, Physician notification, documentation, assessments, shower sheets, skin checks, and weekly skin assessments by the DNS/designee. Licensed staff will communicate changes to DNS/designee of condition changes on residents. Licensed staff will communicate skin condition changes to DNS/designee on residents. Unit managers/designee will review nursing documentation routinely for condition changes/skin changes for appropriateness of documentation and orders. Licensed nurses educated on 8/17/15 & 8/20/15. Re education will be given if needed up to disciplinary action by DNS/designee. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what**	

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	The 3/9/15, 5:55 p.m. nurse's note indicated, "Resident was laid down in bed, notified (name of physician's office) of elevated BP and spoke to (name of physician call center staffperson) for possible orders. (Name of physician's office) said writer should give her PRN (as needed) Zofran (anti-nausea medication) and the wait for thirty minutes to give the antihypertensive medication." This note was recorded as a late entry on 3/11/15 at 1:49 p.m. by RN #12. The 3/9/15, 6:20 p.m. nurse's note indicated, "Writer attempted to give resident medication (Zofran) crushed in apple sauce as ordered. Resident took medications in her mouth but refused to swallow and spit them on the floor. Will continue to try to offer." This note was recorded as a late entry on 3/11/15 at 1:56 p.m. by RN #12. The 3/9/15, 6:30 p.m. nurse's note indicated, "Writer tried to give resident the PRN medications Zofran crushed in apple sauce again and resident spit them out. Resident's BP at this time was 154/127. Will continue to offer medication and monitor BP. This note was recorded as late entry on 3/11/15 at 2:00 p.m. by RN #12. The 3/9/15, 6:40 p.m. nurse's note indicated, "Writer called AHA again told		**quality assurance program will be put into place.** CQI tool for Condition changes/Skin assessments will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters.· The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	them that resident spit out medication Zofran and HTN, AHA said try to give just Zofran and then HTN (hypertension) medication and observe if she will be able to swallow. Resident spit them out again. At this time resident was tearful, diaphoretic, and pale. Will continue to monitor for elevated BP." This note was recorded as a late entry on 3/11/15 at 2:08 p.m. by RN #12. The 3/9/15, 7:20 p.m. nurse's note indicated, "Approx. (Approximately) 7:20pm nurse on 400 hall asked this writer to come to room to assess resident and attempt to give PRN medications. This nurse attempted to give these meds crushed in applesauce to resident. Res was unable to swallow and spit the medications out. Writer assessed BP and results were 221/87. Writer noted that resident was becoming diaphoretic and flushed. Res has no s/s (signs/symptoms) of facial drooping or one sided weakness. Writer spoke w/400 hall nurse and it was decided that it would be best to call (name of physician's office) and 911 and send her to ER for eval (evaluation) r/t (related to) resident's wishes as documented in her POST form. This note was recorded as a late entry on 3/10/15, at 1:12 p.m. by RN #13. The 3/9/15, 7:30 p.m. nurse's note indicated, "Writer got another nurse to attempt (sic) administer Amlodipine and			

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	Zofran medication but resident refused from that nurse as well. At this time resident BP was 221/87. Resident was diaphoretic. Both nurse and writer agreed that resident needed to be sent out to ER. Will continue to monitor for elevated BP. This note was recorded as a late entry on 3/11/15, at 2:24 p.m. by RN #12. The 3/9/15 7:35 p.m. nurse's note indicated, "CNA (Certified Nursing Assistant) was providing care to resident ready to be sent out. Will continue to monitor for elevated V/S (vital signs). This note was recorded as a late entry on 3/11/15 at 2:34 p.m. by RN #12. The 3/9/15, 7:40 p.m. nurse's note indicated, "(Name of physician's office) was called and spoke to Angel who gave order to send her out. 911 was called immediately. Writer tried to call daughter numerous times and left message but did not speak to her. Tried to call daughter's work but co worker stated that she was not there at that time. EMTs arrived at approx. 7:50pm. While EMTs were assessing resident, res daughter called back and asked if there was anything that could be done in house instead of sending resident to hospital. Daughter specifically asked if facility had IM Lopressor to administer. Writer went to facility EDK (emergency drug kit) and checked for IM Lopressor but noted that there was only tablets. At that time daughter stated it			

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	was ok to send resident out. This note was recorded as a late entry on 3/11/15 at 2:30 p.m. by RN #13. The 3/9/15, 7:50 p.m. nurse's note indicated, "EMT arrived at this time. Resident transferred to (name of hospital) ER via stretcher. Report was called to ER nurse. This note was recorded as a late entry on 3/11/15 at 2:58 p.m. by RN #12. The 3/9/15, 11:00 p.m. nurse's note indicated, "Staff called (name of hospital) @ 11 pm to find out how she was doing. Nurse reported that she was admitted for possible stroke. This note was recorded as a late entry on 3/10/15 at 12:30 p.m. by RN #12. An interview was conducted with RN #13 on 8/5/15 at 1:08 p.m. She indicated, after 7:00 p.m., RN #12 asked her if she would help give medications to Resident #D. She indicated hadn't seen Resident #D all day and didn't know what was going on with her. She indicated she assessed Resident #D, who was "kind of rocking" in her bed. She indicated Resident #D was holding onto the side rail of her bed, was getting really sweaty, wouldn't talk and usually did. She indicated she didn't notice Resident #D leaning to the right side or facial drooping. She indicated Resident #D gripped her hands during assessment.			

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	She indicated she assessed her for stroke because she knew her blood pressure was high. She indicated during her assessment she checked her vitals, heart sounds, looked at her face, arms, and legs, turned her to the sides, and palpated her abdomen. She indicated Resident #D's blood pressure was so high, she didn't want to waste any time, and felt more comfortable calling 911. RN #11 and RN #12 no longer worked at the facility and were unavailable for interview. A telephone interview was conducted with the physician's office call center supervisor on 8/4/15 at 1:44 p.m. She indicated there were a total of 3 telephone calls from the facility to the call center on 3/9/15, regarding Resident #D. She indicated the facility informed of vomiting and trouble with blood pressure, but no information on right sided facial drooping or being nonverbal. She indicated Resident #D was sent to the hospital at the last phone call, at 7:34 p.m. Three transcribed telephone conversations from 3/9/15 were provided by the physician's office call center on 8/7/15 at 2:20 p.m. The times were 5:46 p.m., 5:50 p.m., and 7:34 p.m. None of			

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	the 3 conversations referenced the 3/9/15, 5:30 p.m. nurse's notes symptoms of leaning to the right side, laying her head on the table, no verbal response, slight right side facial drooping, face flushed, right side body rigidity, or difficulty sitting upright. The 5:46 p.m. conversation between the physician's call center and the facility was made by RN #12. It included orders for 12.5 mg of Phenergan (anti-nausea medication) and to reattempt blood pressure medicine "1/2 hour afterwards". The 5:50 p.m. conversation was made by RN #12 to inform of Resident #D's current order for Zofran. The call center indicated, "So you can go ahead and give her the Zofran" instead of the Phenergan. The 7:34 p.m. phone conversation was made by RN #13. It indicated, "I have a resident who...um...her blood pressure is 216/157 and we can't get her to swallow any pills to get her...uh...I know my associate had called earlier...um....so we kind of really want to send her out. I just need the ok from you guys." There were no calls made between 5:50 p.m. and 7:34 p.m. to inform the physician of Resident #D's inability to swallow her anti-nausea and blood pressure medication. An interview was conducted with the			

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	DON (Director of Nursing) on 8/6/15 at 10:24 a.m. She indicated she was at the facility on 3/9/15, when Resident #D was in the dining room, but she did not see her in there. She indicated it was common for her to have episodes of high blood pressure, to vomit, and to be difficult to arouse. She indicated she couldn't determine whether nursing staff acted appropriately to Resident #D's medical symptoms. She indicated if she (DON) saw the symptoms RN #11 documented in her nurse's note and considered Resident #D "really different from normal", she would have informed the physician. She indicated she "possibly" would have expected the physician to be notified of right sided body rigidity, right sided facial drooping, and being nonverbal. She indicated she would have expected RN #12 to call the physician's office back 20-30 minutes after the order for antinausea medication to inform them of Resident #D's inability to swallow her blood pressure medication. She indicated she saw Resident #D briefly in the hallway and didn't see any right sided facial drooping. The 3/9/15 Department of Fire and Emergency Patient Care Record for Resident #D's transportation to the hospital indicated they received the call at 7:38 p.m., were on the scene at 7:44			

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	155786		08/07/2015

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	p.m., at the patient at 7:46 p.m., and at the hospital at 8:07 p.m. It indicated, "BP-216/157, s/s-neurological stroke symptoms w/weakness/paralysis, protocol used-suspected stroke, primary impression-stroke/cva (cerebral vascular accident), duration-3 hours, barriers of care-altered mental status, skin-bilateral forearms and hands were red with piticii (sic), asst (assessment) time:...were dispatched to ecf (extended care facility) on increased bp. u/a (upon arrival) found (age, race, and gender of Resident #D) lying supine in bed in care of (name of) crew. Crew stated pt was in dining room around 1700 hours for dinner and staff noticed that she was slumped over to the right side and that she had right sided facial droop. Pt was awake but not alert with obvious right sided facial droop and pt's forearms and hands bilaterally where (sic) red with what appeared to be piticii (sic). pt was unable to answer any questions and attempted to pull away from vitals being taken. Unknown reason for two and a half hour delay in contacting 911. Vitals obtained and pt was hypertensive. Loaded to cot, covered, secured, amd moved to...20 g IV to left AC was attempted but unsuccessful. 20 g IV right hand with lock established, dex 137 mgdl. 12-lead NSR. Transport to (name of hospital) started. Pupils were reactve but sluggish.			

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	Vitals repeated and bp increased. Radio report to (name of hospital) with stroke alert called and we were assigned (room #). Pt condition monitored and comfort measures taken. Bruising noted to pt chest and inside of right thigh. u/a report given and care turned over...." An interview was conducted with NP (Nurse Practitioner) #14, from Resident #D's physician's office, on 8/5/15 at 11:05 p.m. He indicated he remembered Resident #D and that she had uncontrolled hypertension. He indicated if he was given the information in RN #11's 3/9/15, 5:30 p.m. nurse's note, "I would have sent her out right away. I know this patient, and those are classic symptoms of stroke and cardiovascular issues. I would have sent any patient out with those symptoms right away." The 3/9/15, 8:16 pm emergency room hospital records indicated, "Patient presents with Possible CODE STROKE pt slumped over to right with right sided weakness. The history is provided by the nursing home and the EMS (emergency medical staff) personnel...Pt was evaluated by provider at 20:17 (8:17 p.m.)...presents to the ED (emergency department) with right sided facial droop x 1700. Per EMS, pt was seen in the nursing home at dinner with a facial			

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	droop. Per pt's daughter pt has a hx (history) of CVA. Pt's (family member) sts (states)the pt has a hx of weakness and uncoordination... Neurological: positive for facial asymmetry Physical exam: Pupils pin point and to slight left...No response to verbal stimuli. Mild reflexive grip but not on command...Petechiae noted...Scattered petechiae rash on the hands and some old ecchymosis. Radiology Results: Impression: large intracerebral hematoma the left basal ganglia with extension into the ventricular system. Assessment/Plan: Extensive acute intracerebral hemorrhage-CT showed intracerebral hematoma the left basal ganglia. ED discussed with neurosurgery who believe pt is inoperable. Comfort care. Morphine drip, Ativan prn (as needed). Pt is comatose...." The hospital records further indicated Resident #D died on 3/10/15 at 10:30am. An interview was conducted with Family Member #10, Resident #D's POA (power of attorney) on 8/7/15 at 3:34 p.m. She indicated she didn't understand why the facility waited so long to call 911. She indicated the first time she was contacted by the facility on 3/9/15 was			

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	approximately 7:40 p.m. She indicated she had no idea Resident #D was unconscious. 1. b) The clinical record for Resident #D was reviewed on 8/5/15 at 2:00 p.m. The diagnoses for Resident #D included, but were not limited to: hypertension. Resident #D was transferred from the facility to the hospital on 3/9/15. The 2/9/15, 2/16/15, 2/23/15, 3/2/15, and 3/9/15 weekly skin assessments indicated Resident #D had no marks, bruises, discolorations, or rashes. The February, 2015 and March, 2015 progress notes and shower sheets did not reference any marks, bruises, discolorations or rashes on Resident #D. An interview was conducted with Family Member #10, the POA (power of attorney) for Resident #D, on 8/7/15 at 3:34 p.m. She indicated Resident #D had a massive bruise on her chest when observed at the hospital on 3/9/15. She indicated the bruise was approximately 4-6 inches in length and 3 inches wide. She indicated the bruise was yellow and green, and looked like it had been there a while, based on the color. She indicated a few weeks prior to 3/9/15, the facility informed her of a fall the resident had,			

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	but did not inform her of any bruising. The 3/9/15 Patient Care Record from the Department of Fire and Emergency who transported Resident #D from the facility to the hospital indicated, "Narrative...Bruising noted to pt (patient) chest and inside of right thigh." The 3/9/15 hospital note indicated, "Skin Integrity: petechiae; bruising. Skin location: lower arm; upper arm; chest; lower leg; upper leg." An interview was conducted with the DON (Director of Nursing) on 8/7/15 at 3:59 p.m. She indicated she was unaware of any bruising to Resident #D or any event that would have caused bruising to her chest or thigh. The February, 2015 Skin Management Program policy was provided by the DON on 8/7/15 at 2:00 p.m. It indicated, "A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and weekly. Alterations in skin integrity will be reported to the physician and family member(s). All alterations in skin integrity will be documented in the medical record...When a new alteration in skin integrity is identified such as a bruise, skin tear, abrasion, rashes: skin			

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	event will be opened, treatment order obtained as indicated, IDT (Interdisciplinary Team) note to identify root cause and initiate preventative interventions if applicable." This federal tag relates to Complaint #IN00176650. 3.1-37(a)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to timely address a pressure ulcer treatment order for 1 of 3 residents reviewed for pressure ulcers. (Resident #166) Findings include: The clinical record for Resident #166 was reviewed on 7/31/15 at 10:30 a.m. The diagnoses for Resident #166 included,	F 0314	**F0314 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 166 has all treatment orders in place per Physicians orders. Resident # 166 care plan has updated to reflect the physicians order by IDT team. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	09/04/2015

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	but were not limited to, stage 4 pressure ulcer to sacrum. The 7/1/15 impaired skin integrity care plan for Resident #166 indicated the goal was for wounds to heal without complications, and an intervention was treatment as ordered. The 6/23/15 WCS (Wound Care Specialists of Indiana) note indicated, "Wound #2 Sacral is a suspected deep tissue injury pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 2.5 cm length x 4.2 cm width x 0.3 cm depth, with an area of 10.5 sq cm and a volume of 3.15 cubic cm. There is a scant amount of sero-sanguineous drainage noted which has no odor. The wound margin is undefined. Wound bed is 1-25% epithelialization, 26-50% eschar, 1-25% slough. The wound is deteriorating....Additional Orders: Off-Loading Upgrade mattress....Educated nursing staff at bedside regarding proper wound offloading/pressure relief: Yes." The 6/23/15 Wound Skin Evaluation Report, kept by the DON (Director of Nursing), for Resident #166 indicated a description of his sacral wound, but did		**action will be taken. All residents have the potential to be affected.** All residents with pressure sores were/are reviewed to ensure physician's treatment orders were/are implemented by DNS/designee. All residents with skin conditions will have new treatment orders initiated within a timely manner. Education given to licensed nursing staff on the importance of timely addressing Physicians orders. Education given on how to correctly take Physician orders off and place in the resident medical record to be administered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for licensed nurses will be completed by 8/28/15 for timeliness of Physician orders. IDT will review telephone orders routinely in the clinical meeting for new orders and changes. DNS/designee will audit EMAR to make sure orders transcribed correctly. Licensed nurses educated on 8/17/15 & 8/20/15. Re education will be given if needed up to disciplinary action. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** CQI tool for Wound/Assessments will be completed by DNS/designee weekly x 4, monthly x 6, and then	

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	not reference the additional order to upgrade his mattress. There were no orders in the clinical record regarding an upgraded mattress the week of 6/23/15. The 6/30/15 WCS note indicated, "Wound #2 Sacral is a stage 4 pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 3.5 cm length x 7 cm width x 0.6 cm depth, with an area of 24.5 sq cm and a volume of 14.7 cubic cm. There is a scant amount of ser-sanguineous drainage noted which has no odor. The wound margin is undefined. Wound bed is 1-25% epithelialization, 1-25% slough, 26-50% granulation. The wound is deteriorating....Additional Orders: Off-loading Upgrade mattress...worsening wound and noted malnutrition/weight loss-mattress not upgraded last week; still recommend upgrading mattress to LAL (low air loss)" The 6/30/15 Wound Skin Evaluation Report, kept by the DON (Director of Nursing), for Resident #166 indicated, "Get low air loss." An order for Resident #166, dated 7/1/15, indicated, "LAL mattress to bed." An interview was conducted with the DON on 8/7/15 at 11:34 a.m. She		quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action	

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	indicated the weekly WCS notes were sent to her email, and she was responsible for reviewing them. She indicated she was out of the building the week of 6/23/15 when the additional order was made to upgrade Resident #166's mattress. She indicated she did not delegate anyone else in the facility as being responsible for reviewing the WCS notes in her absence. An observation of Resident #166's sacral wound was made on 8/7/15 at 9:10 a.m. The wound was opened, the size of a quarter, with no drainage. White stringy tissue was present in wound bed. The February, 2015 Skin Management Program policy was provided by the DON on 8/7/15 at 2:00 p.m. It indicated, "Pressure reduction devices are to be put in place." 3.1-40(a)(2)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure laundry services closets, with potentially	F 0323	**F0323 - What corrective action(s) will be accomplished for those residents found to have been**	09/04/2015

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	hazardous chemicals in them, had doors that remained closed and locked. This had the potential to affect 2 of 22 residents residing on the 100 hall and 2 of 16 residents residing on the 300 hall. (#236, #139, #80, #182). Findings include: 1. During an observation on 7/29/15 at 10:50 a.m., a door in the 100 hall titled Laundry Services was unlocked. The door had a keypad system to enter the room. In the room, accessible electrical panels were observed with (name of company) Dishwasher Detergent, (name of company) Odor Eliminator, and Neutral Quat Disinfectant in various accessible sections of the room/subroom. During an interview with Unit Manager #3, on 7/29/15 at 10:55 a.m., Unit Manager #3 indicated the door should be locked and she wasn't sure why it wasn't. The following MSDS (material safety data sheets) were provided by the Administrator on 7/30/15 at 9:32 a.m.: The MSDS (material safety data sheets) for Neutral Quat Disinfectant, no date, indicated, "....Signal Word: Danger...Hazard Statements: Causes Serious Eye Damage and Skin Irritation....Start First Aid. Immediately		**affected by the deficient practice.** Resident # 236, # 139, #80, and #182 had potential to be affected but were not as doors have remained locked. Doors will remain locked so resident # 236, # 139, #80, and # 182 will not be able to enter through door. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** Education given to all staff about the importance of laundry service closets, supply rooms with potentially hazardous chemicals remained locked. All staff educated by 8/28/15. All staff daily check the doors on the units to ensure doors remain locked, which will be on going with daily routine checks of the units. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for all staff will be completed by 8/28/15 for safety r/t making sure doors remained locked. Staff to check doors when making rounds on the units. Re education will be given if needed up to disciplinary action. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** CQI tool for	

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	Call a Poison Center or Physician...Keep Out of Reach of Children.... The MSDS (material safety data sheets) for the (name of company) Dishwasher Detergent, dated 3/27/15, indicated, "...Hazard Statements serious eye irritation, causes skin irritation....Do not get in eyes, on skin, or on clothing...." The MSDS for the (name of company) Odor Eliminator, dated 6/2009, indicated, "...Acute Effects Eyes: Slight Transient Irritation, Redness, Pain Skin: Possible Irritation to Sensitive Skin Breathing: Possible Irritation to the Respiratory Systems of Sensitive Individuals....First Aid Eyes: ...Seek Medical Attention as Material May Become Imbedded....Ingestion: Do Not Induce Vomiting. Call A Physician And Or [sic] Poison Control Center Immediately...." 2. During an observation on 7/29/15 at 11:00 a.m., a door in the 300 hall titled Laundry Services was unlocked. The door had a keypad system to enter the room. In the room, accessible electrical panels were observed with Neutral Quat Disinfectant in an accessible section of the room/subroom. The MSDS (material safety data sheets) for Neutral Quat Disinfectant, no date,		Environmental Safety will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action	

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	indicated, "....Signal Word: Danger...Hazard Statements: Causes Serious Eye Damage and Skin Irritation....Start First Aid. Immediately Call a Poision Center or Physician...Keep Out of Reach of Children.... During an interview with LPN #4, on 7/29/15 at 11:05 a.m., LPN #4 indicated the door should remain locked and she was unsure why the door was unlocked. A list titled, BIMS Score, was received from the Administrator on 7/30/15 at 9:32 a.m. The list indicated Resident #236 had a BIMS score of 1 and Resident #139 had a BIMS of 4. Both BIMS scores indicated severe cognitive impairment and both Residents lived on the 100 hall. The list further indicated Resident #80 had a BIMS of 3 and Resident #182 had a BIMS of 2. Both BIMS scores indicated severe cognitive impairment and both Residents resided on the 300 hall. A list titled, Mobility Status-Walk, Roll, Propel Self, was received from the Administrator on 7/30/15 at 12:06 p.m. The list indicated Resident #236 and Resident #139 can roll themselves in their wheelchairs. The list further indicated Resident #80 and Resident #139 can roll themselves in their			

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	wheelchairs. During an interview with the Administrator, on 7/29/15 at 12:33 p.m., he indicated the keypads on the unlocked doors above needed new batteries. 3.1--45(a)(1)			
F 0334 SS=D Bldg. 00	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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	The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on interview and record review, the facility to ensure annual influenza education regarding the benefits and potential side effects of the vaccine were in the clinical records for 3 of 5 residents reviewed for infection control. (Resident #98, #107, & #158)	F 0334	**F0334 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility will ensure that annual influenza education regarding the benefits and potential side effects of the vaccine are provided to resident	09/04/2015

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	Findings include: 1. The clinical record for Resident #98 was reviewed on 8/5/15 at 2:15 p.m. The diagnoses for Resident #98 included, but were not limited to, osteomyletis, peripheral vascular disease, and above the knee amputation. The Minimum Data Set (MDS) assessment, dated 12/31/15, indicated Resident #98 received an influenza vaccine on 10/30/15. A Progress Note, dated 10/30/15 at 1:59 p.m., indicated "res [Resident] annual flu vac given in rt [right] deltoid, temp. [temperature] 97.9." A Influenza Vaccination Consent, which included side effects/education, was signed 9/24/13 and was located in the clinical record. The 2014 documentation of education regarding the benefits and potential side effects of the vaccine was not located in the clinical record. 2. The clinical record for Resident #107 was reviewed on 8/5/15 at 2:18 p.m. The diagnoses for Resident #107 included, but were not limited to, chronic total occlusion of coronary artery, hypothyroidism, and dementia		# 98, # 107, and # 158 for the 2015 year. Influenza Vaccination Consents, which includes side effects/education will be signed and placed in the resident's clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** All new admissions will have education regarding the benefits and potential side effects of the Influenza Vaccine. Influenza Vaccination Consents, which includes side effects/education will be signed upon admission and placed in resident's clinical record. Annually facility residents/responsible parties will be contacted by DNS/CEC/Designee for influenza Vaccine Consent. Education will be given regarding the benefits and potential side effects of the vaccine to resident/family members. Consent that is signed will be placed in resident's clinical record. Education given to the licensed nursing staff/Admissions personnel/Social Service Department on the Influenza Policy for facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Licensed nurses/admissions/Social Service received education on or by	

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	The Minimum Data Set (MDS) assessment, dated 1/27/15, indicated Resident #107 received an influenza vaccine on 10/30/15. A Progress Note, dated 10/30/15 at 2:25 p.m., indicated "res annual flu vac given in left deltoid, temp. 97.8." A Influenza Vaccination Consent, signed 9/18/13, was located in the clinical record, but the 2014 documentation of education regarding the benefits and potential side effects of the vaccine was not located in the clinical record. 3. The clinical record for Resident #158 was reviewed on 8/5/15 at 2:20 p.m. The diagnoses for Resident #158 included, but were not limited to, peripheral vascular disease, malaise, and chronic kidney disease. The Minimum Data Set (MDS) assessment, dated 2/10/15, indicated Resident #158 received an influenza vaccine on 10/30/15. A Progress Note, dated 10/30/15 at 2:06 p.m., indicated "res annual flu vac given in left deltoid, temp. 97.1." A Influenza Vaccination Consent, signed		8/28/15 on the Immunization policy, education, consent, and placement of record in the resident's clinical record. Licensed nurses received education/in serviced 8/18/15 & 8/20/15 on the immunization policy. Admissions Coordinator will review Influenza Vaccine with new residents/family member and placed signed consent in the clinical record. Unit Manager/Medical records/designee will audit new resident admission record to ensure signed Influenza consent is placed in clinical record. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** The resident immunizations CQI tool will be completed by the DNS/designee weekly x 4, monthly x 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance.	

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	9/24/13, was located in the clinical record, but the 2014 documentation of education regarding the benefits and potential side effects of the vaccine was not located in the clinical record. During an interview with the Director of Nursing (DON), on 8/5/15 at 3:14 p.m., the DON indicated she was unable to locate the documentation of education regarding the benefits and potential side effects of the vaccine in the clinical record for the 3 residents above. The DON indicated she will look to see if the documentation was in another location in the facility. On 8/7/15, at 12:32 p.m., the DON indicated the facility was unable to locate documentation of the above Resident education for the influenza vaccines. A policy titled Influenza Vaccine, dated 7/2013, was received from the Director of Nursing on 7/29/15 at 1:00 p.m. The policy indicated, "..."Annually residents will be provided with the opportunity to receive the influenza vaccine....2. Each resident and/or responsible party will receive education regarding the vaccine based upon up to date CDC [Center for Disease Control] information. 3. Each resident or responsible party will sign the Influenza Vaccination Consent Form....5.			

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	Influenza Vaccination Consent Form is placed in medical [sic] record under the admission information section...." 3.1-50(a)(1)			
F 0465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 provide a home like environment for 1 of 40 residents' rooms observed. (Resident #103) Findings include: An observation was made on 7/30/15 at 9:30 a.m. Resident #103's room had a urine odor. An observation was made on 7/30/15 at 1:51 p.m. Resident #103's room had a urine odor. An observation was made on 8/5/15 at 11:00 a.m. Resident #103's room had strong urine odor. An interview was conducted on 8/5/15 at 11:05 a.m., with RN #5 in Resident #103's room. RN #5 indicated this room always smells like urine, but today was	F 0465	**F0465 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 103 has been provided with homelike environment. Staff checking resident # 103 room daily for any negative odors and addressing in timely manner. Resident # 103 was deep cleaned by Housekeeping staff. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** Education given to all staff on the importance of creating a homelike environment for the residents. Rounds will be made daily by management staff. Any unusual odors or findings will be reported in the morning meeting to be addressed in a timely manner. All rooms were checked by Customer	09/04/2015

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	stronger than normal. She was not sure where the urine odor is coming from. An interview was conducted on 8/5/15 at 11:25 a.m., with Housekeeping #1. She indicated Resident #103's room always smells like urine. She indicated the resident's room is cleaned every day, and the smell always comes back. An interview was conducted on 8/5/15 at 1:00 p.m., with the Director of Nursing(DON) in Resident #103's room. She indicated she does smell a urine odor in the room, but has never noticed it before. An interview was conducted on 8/5/15 at 1:00 p.m., with the DON. She indicated the urine odor in Resident #103's room was coming from her roommate's personal chair. The DON indicated Social Services had contacted roommate's family to remove or clean the chair. An interview was conducted on 8/5/15 at 1:40 p.m., with Resident #103's power of attorney (POA). He indicated the urine odor was very offensive, and he had been searching for the source of the urine odor for atleast a month possibly longer. The POA indicated he had cleaned and brought in deodorizer agents himself and had been unsuccessful of removing the		Care Representative to ensure no other room had a urine odor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for all staff will be completed by 8/28/15 for making room rounds and checking for unusual odors/findings. Reports to made to IDT in the morning meeting to be addressed in timely manner. ED/designee will ensure any room identified to not be homelike will be checked to ensure room is clean and in good repair. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** CQI tool for Dignity/Accommodation of needs will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters.· The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	odor. He also indicated he had had to forewarn family members prior to visiting of the presence of the urine odor in the room. The POA indicated he had discussed the concern with the facility's housekeeping. The facility's housekeeping cleans the room, but the urine odor returns. An observation was made on 8/6/15 at 2:00 p.m. Resident #103's room had strong urine odor. An interview was conducted on 8/7/15 at 9:50 a.m., with the Social Services Assistant. She indicated housekeeping and the Customer Care Coordinator was aware of the urine odor concern in Resident #103's room. They believe the odor is coming from her roommate's chair. Housekeeping has attempted to clean and deodorize the room, but has been unsuccessful of the removal of the odor. An interview was conducted on 8/7/15 at 10:35 a.m., with the Social Services Director and the Social Services Assistant . They indicated they removed the chair from Resident #103's room, and no longer believe the urine odor is coming from the chair. Social Services Director indicated she has notified Hospice to replace Resident #103's			

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	mattress. Social Services Director also indicated the Customer Care Coordinator was made aware of the urine odor concern about 2 weeks ago. 3.1-19(f)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to maintain accurate documentation for 1 of 22 residents' records reviewed. (Resident #E) Findings include: The clinical record for Resident #E was reviewed on 8/4/15 at 12:07 p.m. Resident #E was admitted to the facility on 7/10/15. The diagnoses for Resident #E included, but were not limited to, muscle back spasm, osteoporosis, and rib	F 0514	**F0514 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There is no corrective action for resident E as she no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected.** Licensed nurses will be educated/in serviced by the	09/04/2015

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	fracture. A Medication Administration Record dated, 7/10/15-7/31/15, indicated Resident #E was to receive an oral dose of 50 milligrams of tramadol four times a day due to acute pain. The administration times were 8:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m. This record indicated the administration of Resident #E's tramadol was the following: 7/10/15 indicated the scheduled 5:00 p.m., dose of tramadol was "Not Administered: Drug/Item unavailable." 7/10/15 indicated the scheduled 9:00 p.m., dose of tramadol was "Not Administered: Drug/Item unavailable." 7/11/15 indicated the scheduled 8:00 a.m., dose of tramadol was signed off by the staff as administered. 7/11/15 indicated the scheduled 12:00 p.m., dose of tramadol was "Late Administration: Administered late." A Medication Administration Record dated, 7/10/15-7/31/15, indicated Resident #E was to receive an oral dose of 2 milligrams of diazepam twice a day for back muscle spasm. The administration times were 9:00 a.m., and		DNS/designee on Accurate documentation on the EMAR and following Physicians Orders by 8/28/15. Education/in service for licensed nurses held 8/17/15 & 8/20/15 for Documentation on the EMAR, following Physicians orders, and procedure for Discontinuation/hold orders. All new admissions will be reviewed/audited for physician/treatment accuracy of orders by DNS/designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** IDT will review the admission/physician orders at the clinical meeting routinely to verify accuracy. Unit Managers/designee will perform medication pass with nurses on different shifts to check that medication administration and documentation on the EMAR is within compliance and accurate. The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed and documentation is complete. Education may be on going with staff, non compliance with procedures may result in disciplinary action. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.** The Unit Managers	

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	9:00 p.m. This record indicated the administration of Resident #E's diazepam was the following: 7/10/15 indicated the scheduled 9:00 p.m., dose of diazepam was "Not Administered: Drug/Item unavailable." 7/11/15 indicated the scheduled 9:00 a.m., dose of diazepam was signed off by the staff as administered. A progress note dated, 7/11/15 at 11:15 a.m., indicated diazepam and tramadol had not been delivered to the facility. The staff had placed a call requesting scripts, so medications could be delivered the night of July 11th. A progress note dated, 7/11/15 at 3:24 p.m., indicated the facility needed hard scripts for authorization to fill the controlled medications. A progress note dated, 7/11/15 at 4:20 p.m., indicated "Received confirmation of pharmacy receipt of script for tramadol. Family upset that med not received, explained that med would come in tonight and that we now could get auth (authorization) code to obtain med from the (medication dispensing system), family not satisfied with that and obtained home med from AL (assisted		will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2 consecutive quarters.· The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. · Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	living). accuracy of count verified x 2 nurses and supervisor, and is packaged in blisterpack from (name of pharmacy). Assured family that resident would receive med as ordered." An interview was conducted on 8/5/15 at 2:22 p.m., with the Director of Nursing (DON). The DON indicated the facility does need a hard script for tramadol. She also indicated Resident #E's 7/11/15 progress notes were correct, and her Medication Administration Record was incorrectly signed off as medications were given. An interview was conducted on 8/7/15 at 2:40 p.m. with the Director of Nursing (DON). The DON indicated there was no written policy on accuracy of documentation. She indicated it was the facility's expectation that documentation is entered in the system accurately. This Federal tag relates to Complaint IN00179129. 3.1-50(a)(2)			
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program	F 9999	**9999 -What corrective action(s) will be accomplished for those residents found to have been**	09/04/2015

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	planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff received annual in-service education on residents rights for 6 of 10 staff members reviewed for residents' rights in-service education. (LPN #4, Dietary #5, CNA #6, RN #7, Dietary #8, CNA #9) Findings include:		**affected by the deficient practice.** No residents found to be affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. All staff will be educated/in serviced by 8/28/15 on Resident Rights. Staff will continue to complete in service training/education monthly on the Care to learn system on different required subjects. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**. Education/In service for all staff will be completed by 8/28/15 for Resident Rights. CEC will track employees on Care to learn system to make sure monthly in-services completed in timely manner. CEC/designee will be in serviced by Relias regarding tracking resident rights in-service. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. .** CQI tool for In-service/education will be completed by DNS/designee weekly x 4, monthly x 6, and then quarterly until continued compliance is maintained for 2	

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	The Employee Records form and 10 employee personnel files were reviewed on 8/6/15 at 3:30 p.m. The Employee Records form indicated the following start dates: LPN #4-9/8/13, transferred to facility 4/17/15 Dietary #5-6/20/11 CNA #6-9/11/13 RN #7-11/20/13 Dietary #8-2/1/12 CNA #9-10/7/13 The employee personnel files for LPN #4, Dietary #5, CNA #6, RN #7, Dietary #8, and CNA #9 did not include verification of annual training for the listed employees on residents' rights. On 8/7/15, at 9:10 a.m., the following Resident's Rights In-Service verification were received from the Administrator: LPN#4=completed on 8/7/15, Dietary #5=completed on 8/6/15, RN #7=completed on 8/7/15, Dietary #8=completed on 8/7/15 and CNA #9=completed on 8/7/15. There was no verification for CNA #6 of completion of a current Resident's Rights In-Service. During an interview with the Administrator, on 8/7/15 at 2:50 p.m., the Administrator indicated he was unable to locate the previous annual training for the		consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155786		08/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	above employees because the training was not done for 2014 due to a computer scheduling conflict. The New Punch Detail Report indicated the number of worked days for May, June, and July 2014 as follows: LPN #4=60 days, Dietary #5=39 days, CNA #6=23 days, RN #7=63 days, Dietary #8=73 days and CNA#9=63 days. A policy titled, Educational Inservices and Training, no date, was received from the Director of Nursing on 8/7/15 at 4:49 p.m. The policy indicated, "Purpose: To provide guidance in regards to State regulations and [name of corporation] expectations of the delivery of educational in-services and training programs to all staff. The policy will serve as a guide for staff in effectively utilizing training and staff development resources, which is designed to help the organization to fulfill its mission....1. The facility must provide the following State required in-services programs annually...ii. Resident Rights...."			