STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00169328. Complaint IN00169328- Substantiated. Federal/State deficiency related to the allegations are cited at F-156 & F-309. Survey dates: March 25, 26, 27, 30, 31, & April 1, 2015 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census bed type: SNF/NF: 123 Total: 123 Census payor type: Medicare: 9 Medicaid: 86 Other: 28 Total: 123 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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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F 0156 SS=C Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to post advocacy information in an area visible for the residents and public. This had the potential to affect all 123 residents who resided in the facility. Findings include: An interview with the Resident Council President on 3/27/15 at 3:40 p.m., indicated she was not aware of who the Ombudsman was or where the contact information for the Ombudsman was posted. An interview with the Administrator on 3/31/15 at 1:53 p.m., indicated the contact information for the Ombudsman or Adult Protective Services was not posted. The information had been posted on a wall near the entrance with other framed advocacy information but had been taken down for remodeling. An interview with the Administrator on 4/1/15 at 4:38 p.m., indicated she was unsure of how long the advocacy information had been stored in an office and the remodeling had not been completed yet.	F 0156	Tag F156 Ambassador Healthcare requests an informal disputeresolution for F156, due to the unreasonable scope and severity associated withthe tag. We respectfully requestdeletion of the tag. In support for ourrequest, please consider the following: 1. Thefacility has always posted a poster containing information including contactnumbers for the Ombudsman. It has beenposted on the wall outside the administrator's office (now the admissionsoffice) for the last several decades. 2. Thefacility, in its attempt to improve the cosmetics and accessibility of theinformation had removed the poster, which was in poor condition, to have a newone matted in a more attractive frame. The new poster was at the framers at the time of survey. The old poster was in the admissions officeon a shelf. When the old poster wasshown to the surveyors the surveyors' noted to the staff that the old postedlooked bad because someone had written "Good Luck" with a happy face on the oldposter so it was clear to them at the time that we did indeed needed a newposter. 3. Theinformation was always accessible from the brochures in the lobby and in theAdmission /Marketing Director's office. The	05/01/2015

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	Resident Rights information given to the residents on admission was provided by the Social Service Designee on 3/31/15 at 1:50 p.m. The Resident Rights information indicated "...Your Have The Right ...To receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. To have access to any individual representing state or federal agencies, any authorized representative of the state, your individual physician, the state and local long-term ombudsman, and the agencies responsible for the protection and advocacy systems for developmentally disabled individuals and for mentally ill individuals. The Facility must provide reasonable access to any Resident by any individual that provides health, social, legal, or other services to you...." This federal tag relates to Complaint IN00169328. 3.1-3(j)(3)		Admission/Marketing Director makesthis information readily known to the Residents and Responsible Parties uponeach admission and a copy of the brochure is part of the admissions packet. Surveyorwas informed that information was given upon admission with resident and/ orresponsible party a copy of signed receipt. 4. Thebrochures were also available in the lobby. A copy of the brochure is attached. 5. DuringResident Counsel meeting the Activity Director has made residents aware of theOmbudsman and his services. 6. TheOmbudsman makes visits, in his official capacity, at least one time a month tothe facility and visits with the residents. He also participates in weekly church services at the facility as aminister. He is also regularly contactedby the staff and or residents to come and talk to the residents on a variety ofissues. 7. TheAdministrator had obtained the new poster from the Ombudsman to be framed priorto survey. 8. Itwas always the intent to replace the poster with a new one. It was off the wallfor a short amount of time and only because it was defaced by a guest immediatelyprior to survey. 9. Theold document was placed back on the hallway wall immediately upon surveyor'sobservation. 10. Onfurther interview with Resident Council President on 04/13/2015,	

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			the ResidentCouncil President agreed that the Admission Coordinator provides the brochureto all residents. Quizzed in regards tothe Ombudsman and if she knew him. Shestated “No”. Statement rephrased tostate his name and she stated “Oh yes, I know him”. We determined that resident did not put thetitle of Ombudsman with his name. 11. Ombudsmanattended Resident Council meeting on 4/17/15 and explained services. F 156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES I. TheResident Council President has personally been given a pamphlet titled IndianaOmbudsman Program. The AdmissionsCoordinator gave the brochure to the resident and she acknowledged she knew hisname and services. Further, the familyinvolved with her care has been updated with the Ombudsman’s information. II. Currentresidents residing in the facility have been given new pamphlets titled IndianaOmbudsman Program with services explained. Residents with difficulty in understanding; the responsible parties havebeen mailed a new brochure. Theombudsman, Paul Register, is meeting with resident council on April 17, 2015 tointroduce him and the services he provides. New admissions will continue to receive the required	

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			information inregards to the Indiana Ombudsman Program during the admission process. Receipt will be documented in the admissionfile. III. Asystemic change includes placing a new poster titled Indiana Ombudsman Programin the main north hallway. TheAdmissions Coordinator will continue to make this information available to newresidents and responsible parties upon the admission conference with confirmation receipt. IV. Thefacility Quality Assurance goal has been written to review regulatedinformation postings. These postingswill be monitored quarterly for updates by the Administrator and/ordesignee. The compliance will be sharedwith the Quality Assurance Committee during the quarterly meetings. The administrator and/or designee willmonitor for posted advocacy information in public area 1 time per week for 6months. V. CompletionDate: May 1, 2015	
F 0309 SS=D 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 observation, interview and record review, the facility failed to	F 0309	F 309 PROVIDE CARE/SERVICES FOR	05/01/2015

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	assess, monitor and implement non pharmalogical interventions for pain management to ensure pain relief was achieved for 1 of 3 residents reviewed for pain recognition and management (Resident #A). Finding include: Review of the clinical record of Resident #A on 3/27/15 at 10:00 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, seizure disorder, cerebral aneurysm (status post rupture), hypertension, depression and dementing illness with associated behavioral symptoms. The pain screening and assessment record for Resident #A, dated 12/5/14, indicated the resident had no pain. The Admission Minimum Data Set (MDS) assessment for Resident #A, dated 12/14/14, indicated the resident's BIMS (Brief Interview for Mental Status) was 12, indicating moderately impaired cognition and presence of pain- none. The fax to the physician, dated 3/17/15, indicated Resident #A was complaining of right shoulder pain. The resident requested a heating pad. The suggestion was Lidoderm 5% patch every day. The		HIGHEST WELL BEING I. Resident#A received an order for topical pain relief gel, biofreeze, every shift to theaffected area for pain relief. Lidocainepatches were discontinued due to noncompliance with resident leaving patch inplace. On 4-1-15, pain assessment wascompleted. Staff was immediately re-educated on non-pharmalogical interventions for pain management andimmediate need to do pain assessment and plan of care. II. Currentresiden ts residing in the facility will be reassessed for pain and receive anupdated pain assessment. Those identifiedexhibiting pain will have physician notified and receive treatment as ordered. Plan of care will updated at that time. III. Asystemic change includes those residents with new signs and symptoms of	

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	physician ordered Lidoderm patch every. The clinical record of Resident #A indicated no pain assessment was completed or monitoring of the resident's pain on 3/17/15 or after this date. The record indicated no non pharmalogical interventions were implemented to relieve the resident's pain. Interview and observation with Resident #A on 3/30/15 at 1:41 p.m., indicated she was experiencing pain on the right side of her neck and left arm. She indicated the pain was rated as a 6 on the 1-10 pain scale. The resident indicated she did not want to complain. She indicated the pain comes and goes. The resident indicated she did not have a Lidoderm patch on because she did not feel like it helped her pain. The resident indicated Motrin or Tylenol was not very effective for her pain. She indicated in the past Darvocet (pain medicine) seemed to work best for her pain. Resident #A was rubbing her arm and neck during the interview. Interview with LPN #2 on 3/30/15 at 2:00 p.m., indicated he was not aware Resident #A was experiencing pain. LPN #2 indicated he would talk with the resident. The nurses note for Resident #A, dated		pain,residents with new orders for pain management, including non-pharmalogicalinterventi ons, will be recorded on the 24 hour report. The 24 hour report will be reviewed daily(Monday through Friday) by the Director of Nurses or an administrative nurse toensure the pain assessment and plan of care have been updated as needed. The Director of Nurses will also review alltelephone orders for new pain medication, including those of non-pharmalogicalinterventi ons, to ensure the pain assessment and plan of care have been updatedas needed. Education was provided to allnurses regarding assessment, monitoring, and implementation ofnon-pharmalogical interventions for pain management to ensure pain relief. This education will also include recordingresidents with new orders for pain management, including	

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	3/30/15 at 2:00 p.m., indicated the resident complained of right shoulder and right neck pain. An order was received for Tylenol 650 milligrams every four hours prn (as needed) for pain or temperature. Tylenol was given and the resident rated her pain as a 6 on the 1-10 pain scale. The resident's Lidoderm patch was missing and the resident stated "They don't help". Interview with LPN #1 on 3/30/15 at 3:30 p.m., indicated Resident #A had complained of arm pain to her in the past and she received an order from the physician for a Lidoderm patch. Interview with Resident #A and the Social Service Director (S.S.D.) on 4/1/15 at 12:08 p.m., indicated she was having some pain in her right arm. The S.S.D. indicated yes sometimes she does complain of pain in her right arm. Interview with the MDS Coordinator on 4/1/15 at 12:20 p.m., indicated Resident #A did not have an updated pain assessment or non pharmalogical interventions for pain management. The pain management policy provided by the Director Of Nursing (DON) on 3/31/15 at 9:10 a.m., indicated the purpose of the policy was to ensure pain		non-pharmalogicalinterventi ons on the 24-hour report. IV. TheDirector of Nurses, and/or designee will review the 24-hour reports and the telephoneorders and provide a clinical record review of residents experiencingpain. This review will be to identifythat residents with new orders, including non-pharmalogical, will have updatedpain assessments and plan of care. Theseaudits will occur for the minimum of 5 times a week for 6 months. Any identified concerns from audits will beaddressed immediately. The results of these audits will be discussed at the facilityQuality Assurance Committee meeting and frequency and duration of reviews willbe adjusted as needed. V. CompletionDat e: May 1, 2015	

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	management by evaluating the resident for presence of pain, ensuring that appropriate medicine and/or treatment was given and that ongoing assessment for pain control was provided. "It is the policy of this facility that residents will be properly assessed for the presence of acute or chronic pain, and if pain is present, it will be managed, treated, and relieved." "A pain assessment will be completed on any resident identified as having pain and residents with diagnosis that have pain as a common symptom." "A standardized pain assessment instrument will be used." "Assessing location, characteristics, onset, frequency, intensity, duration, precipitating factors and effectiveness of pain control measures." "Upon completion of the pain assessment, appropriate goals and approaches for pain relief will be discussed and implemented after consultation with the attending physician, other health care professionals, and resident/responsible party as appropriate." "A plan of care with interventions for pain relief will be developed and implemented." "The plan of care will include the use of medications and alternative measures as appropriate." "Pain medicine prescribed for a resident must be assessed on admission or at the time first prescribed and on an ongoing basis."			

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	This Federal tag relates to Complaint IN00169328. 3.1-37(a)			
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 and interview, the facility failed to maintain water temperature at a safe temperature for 4 of 10 random water temperatures tested. (Room 210, 215, 217, and 219) Findings include: On 3/26/15 at 3:03 p.m., 10 random water temperatures were tested in resident's bathrooms with the Maintenance Supervisor. Resident's bathroom temperatures indicated the following: Room 210 was 129 degrees, room 215 was 125.3 degrees, room 217 was 124.2 degrees, and room 219 was 123.4 degrees. The Maintenance Supervisor indicated he tried to keep water temperatures between 110 to 120 degrees. If the water	F 0323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES I. Thefacility has taken an aggressive approach to identify, diagnosis, and repair themixing valve issues which may affect the water temperatures. A plumbing contractor has scheduled therepair for the valve on April 22, 2015 affecting rooms 210, 215, 217, and219. The water is now maintained between110 to 120 degrees. Daily watertemperature checks are being monitored until the repair is accomplished	05/01/2015

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	temperatures exceeded 120 degrees he adjusted the mixer valve to turn the water temperature down. He performed random water temperatures every 2 weeks. The Water Temperatures policy and procedure provided by the Administrator on 4/1/15 at 3:04 p.m., indicated the following: "Policy: To ensure the safety of our Resident. Procedure: Hot water temperatures for all bathing and hand washing facilities will be controlled by automatic control valves. Water temperatures at point of use will be maintained between 100 degrees and 120 degree Fahrenheit. Maintenance to do monthly random checks on all hallways to ensure that water temperatures are within guidelines." 3.1-45(a)(1)		withadjustments made as needed. Residentsoccupying those specific rooms are determined to have the potential to beaffected. II. Currentresiden ts residing in the facility will have daily random water temperaturechecks until the repair is accomplished with adjustments as needed. III. Asystemic change includes implementing an updated policy titled, “WaterTemperatures,” with time frames for monitoring. Maintenance will monitor water temperatures daily until the repair isaccomplished. Additional monitoring ofwater temperatures will be performed 1 time per week for one month and thenonce every two weeks indefinitely. Thesetemperatures will be logged. The MaintenanceSupervisor will inform the Administrator of any temperatures outside the rangefor prompt repair. Additionally, mixingvalves	

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			will be placed on a six month schedule formaintenance as needed. This will also belogged. IV. Thefacility Quality Assurance goal has been written for monitoring watertemperatures on a quarterly basis. TheMaintenance Supervisor is responsible to the Quality Assurance Committee to ensurewater temperatures are maintained at a safe level. This information will be reviewed at QualityAssurance meetings. Recommendations forcompliance will be made at this time. Ifwater temperatures occur outside the range, daily water temperature checks willbe implemented with prompt adjustments until repaired. V. CompletionDate: May 1, 2015	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or			

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NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN 47330	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure dishes were free of food particles when stored as clean, failed to clean the outside of the deep fryer, and had folded paper under a table leg during 2 of 2 observations. This had the potential to affect 108 of 123 residents residing in the facility. Findings include: On 3/31/2015 at 1:42 p.m., with the Dietary Supervisor, the following was observed: - A heavy accumulation of thick brown grease had dripped down both sides of the deep fryer, and down the left side of the range that set to the right of the deep fryer. The grease had dripped on the floor between the range and the deep fryer. On the left of the deep fryer, grease had accumulated along the edge of a stainless steel countertop. The Dietary Supervisor indicated it was hard to clean around the deep fryer because it is so close to the range and the deep fryer has to set there because it has to be under the range hood.	F 0371	F 371 FOOD PROCURE, STORE/PREPARE/SERVE -SANITARY I. OnApril 6, 2015, the stove and deep fryer was professionally cleaned and thegrease was removed. The chemical companyserviced the dish machine on April 6, 2015 and was determined to be functioningnormally. Adjustments were additionallymade per the Administrator's request in the rinse cycle and temperatureboost. The machine is a low temperaturechemical sanitizer. II. Anin-service was given to all dietary staff by the chemical company on April 15, 2015. The in-service instructed staff on dishmachine policy and procedure and proper function and cleaning. In addition, a general sanitation in-servicewas	05/01/2015

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	- Folded paper was observed under one of four legs of the stainless steel table on the range side of the serving area. The Dietary Supervisor said the shorter table leg made the table unsteady, and the paper helped make it steady. - 8 of 29 bowls that were stored as clean had white particles adhered to the inside of the bowls. A weekly deep fryer cleaning sign off sheet was provided by the Dietary Supervisor on 4/1/15 at 12:26 p.m. The sign off sheet indicated the last time the deep fryer was cleaned was on 3/20/15. On 4/01/2015 at 1:58 p.m., the Dietary Manager indicated only the inside of the deep fryer is cleaned on the schedule; they can never clean the outside of the deep fryer because it is so close to the range. She said the deep fryer was last moved on 3/30/15, when the burners were replaced on the range, but the oven people didn't clean the deep fryer when they were in. 3.1-21(i)(3)		included. All residents residing inthe facility, who receive dietary trays, are determined as having the potentialto be affected. III. Asystemic change includes kitchen cleaning schedules. These schedules have been reviewed by theDietary Manager and Administrator. Updates in the cleaning schedule have been implemented and in-servicedto dietary staff on April 15, 2015. Maintenance work orders for equipment repair will be monitored by theDietary Services Manager weekly. IV. Thefacility Quality Assurance goal has been written for kitchen sanitation. These will be reviewed by the QualityAssurance Committee quarterly for revision and correction as needed. The Dietary Services Manager andAdministrator will monitor for staff compliance weekly indefinitely. Any identified concerns from	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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			audits will beaddressed immediately. The frequency and duration of reviews will be adjusted as needed. V. CompletionDate: May 1, 2015	
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 record review and interview, the facility failed to ensure clinical records were accurately documented, in that wound assessments had incorrect dates for 1 of 22 residents reviewed for complete and accurate documentation. (Resident #118) Findings included: Resident #118's clinical record was reviewed on 3/31/2015 at 4:04 p.m. The record indicated Resident #118 had	F 0514	F 514RECORDS-COMPLETE/ACCURATE/ACCESSIBLE I. Resident#118 has been discharged. II. Currentresidents residing in the facility with weekly wound evaluation and flowrecords have been reviewed by the wound nurse and the Director of Nurses toensure the wound	05/01/2015

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	diagnoses that included, but were not limited to, acute kidney failure, chronic kidney disease, atrial fibrillation, peripheral vascular disease, neuropathy, infection in the bone, chronic airway obstruction, urinary obstruction, urinary retention, infection and swelling in legs, difficulty in walking, and muscle weakness. Resident #118 had been discharged on 1/18/15. The clinical record indicated the following wound assessments had incorrect dates: A "Weekly Wound Evaluation and Flow Record" for a pressure area on the right buttock was dated as being completed on 12/24/15. A "Weekly Non-pressure Wound Evaluation and Flow Record", for the left heel was dated as being completed on 12/22/15. A "Weekly Non-pressure Wound Evaluation and Flow Record", for the right heel was dated as being completed on 12/22/15. A "Weekly Skin Sweep" assessment was dated on 1/22/15 and 1/29/15 and		assessments have correct dates. III. Asystemic change includes a designated wound nurse to follow wounds and skinconcerns five days a week. This woundnurse is responsible for the all wound education, evaluation of wounds,documentation of wounds, change of treatments, and accuracy of wounddocumentation. Education was provided to all nurses regardingaccurate documentation of wound assessments. IV. TheDirector of Nurses, and/or wound designee will review the weekly woundevaluation and flow record. This reviewwill consist of accuracy of documentation. These audits will occur for the minimum of 5 times a week for 6months. Any identified concerns fromaudits will be addressed immediately. The results of these audits	

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	indicated on those dates "No new skin impairment". On 4/01/2015 at 4:28 p.m., the Director of Nursing indicated the dates on Resident #118's wound assessment sheets were incorrect. A policy and procedure, for "Clinical Records - Content and Maintenance", was provided by the Administrator on 4/1/15 at 3:42 p.m. The policy indicated, but was not limited to: "Purpose: 1. To be used as a separate, individualized legal document...4. To be a means of documentation of the resident's course of illness and treatment....Policy: A resident's clinical record will be an accurate and comprehensive record of the resident's interdisciplinary health assessments, ongoing condition and care...." 3.1-50(a)(2)		will be discussed at the facilityQuality Assurance Committee meeting and frequency and duration of reviews willbe adjusted as needed. Completion Date: May 1, 2015	