STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit resulted in an Extended Survey, Substandard Quality of Care and Immediate Jeopardy. Survey dates: January 16, 17, 18, 19, 22, 23, and 24 2018. Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census bed type: SNF/NF: 55 Residential: 8 Total: 63 Census payor type: Medicare: 8 Medicaid: 45 Other: 2 Total: 55 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 30,	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 23rd 2018 for the annual licensure survey conducted on January 16th, 2018 through January 24th, 2018.	

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

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	2018			
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to maintain residents' dignity related to resident services for 2 of 31 residents reviewed for dignity. (Residents 53 and 34) Findings include: 1. During an interview on 01/16/18 at 03:34 P.M., Resident 53 indicated he did not get the help he needed going to the bathroom. When he activated his call light and asked for assistance to the bathroom, staff would tell him to go on himself and they would clean it up later. During an interview on 01/19/18 at 10:51 A.M., Resident 53, while laying in bed, indicated he had used his call light to get help following a bowel movement at 08:00 A.M. Staff told him they, "would get to him	F 0557	F 557 The facility does provide Dignity and respect to all residents. Resident 53 has been discharged to a sister facility per his choice to be closer to family Resident 34 has been given a shower and will continue to receive showers routinely Any resident has the potential to be affected by this alleged, deficient practice. Nursing staff will be in-serviced by the Administrator/AIT/DON/or Designee regarding resident rights and providing dignity with an emphasis on prompt toileting and incontinent care as well as providing showers as scheduled on or before Feb. 22nd, 2018.	02/23/2018

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	when they could get to him." Staff had not been back in his room since 08:00 A.M., and he had been sitting in his own stool since that time and was very upset. During an observation on 01/19/18 at 10:56 A.M., Resident 53 was provided incontinence care by RN (Registered Nurse) 12. As the nurse, wearing gloves, removed the resident's brief, dried caked on feces was noted up to two inches below his navel on his abdomen, on the outside of his brief, on his gown, on the bedspread, on the call light, on top of the resident's left thigh, in the center of his chest, and totally encompassing the resident's peri anal area. The room smelled strongly of bowel movement. The clinical record for Resident 53 was reviewed on 01/22/18 at 10:22 A.M. A quarterly MDS (Minimum Data Set) assessment, dated 12-12-17, indicated the resident was cognitively intact, needed extensive assistance of two staff for personal hygiene, was always incontinent of urine, and frequently incontinent of bowel. Diagnoses included, but were not limited to, Multiple Sclerosis. 2. The clinical record for Resident 34 was reviewed on 01/22/18 at 11:14 A.M. The most recent admission MDS assessment dated 03/14/17 indicated the resident was		The DON/Designee will observe/interview 5 residents a week X 4 weeks,then 5 residents a month X 5 months to ensure Dignity remains in practice. Corrective action will be taken immediately on any area of concern. DON/Designee will audit residents shower sheets weekly and interview residents to ensure that they have received their showers as scheduled The DON/Designee will report findings to the QA/QAPI committee monthly x 6mo. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of compliance: 2/23/18	

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	moderately cognitively impaired. Diagnoses included, but were not limited to, hypertension, diabetes, and dementia. The resident needed physical assistance with part of her bathing. During an interview on 01/18/18 at 10:43 A.M., Resident 34 indicated on 11/24/17, the day after Thanksgiving, there was only one aide working and no one got their showers that day. She had an appointment that following Monday and went to the appointment "smelling like a dirty little piggy", and it happens quite often. The Wing 3 CNA Assignment Sheet was provided by RN 10 on 01/22/18 at 4:07 P.M. and was reviewed at that time. The CNA sheet indicated Resident 34 received her showers during the dayshift on Tuesdays and Fridays. During an interview on 01/23/18 at 2:57 P.M., CNA 17 indicated Resident 34 was compliant with care, always took her showers, and needed assistance with showers. On 01/24/18 at 11:38 A.M. Resident 34's Resident Care Record/CNA sheets were reviewed. The sheets lacked documentation for showers on 11/10/17, 11/17/17, and			

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	11/24/17. The progress notes lacked documentation the resident refused/ did not receive a shower for the above dates. During an interview on 01/24/18 at 02:30 P.M., the Corporate MDS Coordinator indicated if the showers were not documented then they weren't done and was unable to locate skin sheets that the CNA's filled out when a shower was given for the dates 11/10/17, 11/17/17, and 11/24/17. During an interview on 01/24/18 at 02:30 P.M., the MDS Coordinator indicated if a resident refused a shower three times then she would notify the family and was unaware of Resident 34 refusing her showers. During an interview on 01/24/18 at 03:05 P.M., CNA 18 indicated she documented showers on a shower sheet and CNA sheet and turn them into the Director. If the shower spot is left blank on the CNA sheet it would mean the resident didn't get their shower. Resident's wouldn't get showers if there was only one aide on the hall. The current facility policy titled "Resident Rights", and undated, was provided by the AIT on 01/24/18 at 04:00 P.M. and reviewed at that time. The policy indicated, "...Dignity. A facility must care for its			

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	residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..." 3.1-3(t)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at			

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	the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. [illegible]	F 0578	F 578 The facility does offer and allow residents to make a choice regarding their advanced directives Resident #17 has a current advanced directive in her chart, a care plan to match and the physician has been notified of desired code status Any resident has the potential to be affected by this alleged, deficient practice. All residents' charts have been audited for advanced directives, care plans for choice on advanced directive and physician notification of the advance directive The SSD will be educated by the Admin/AIT/Designee on or before Feb. 22nd, 2018, on offering and completing advanced directives,	02/23/2018

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			where to place in the resident's medical record, updating resident care plans and physician notification of resident's advance directive choices. The Admin/AIT/DON/Designee will review 5 resident records weekly x 4 weeks, then 5 resident records a month X 5 months for advanced directives, proper placement, up to date care plans and verification of physician notification. Corrective action will be taken immediately for concerned areas. The AIT/Designee will report findings to the QA/QAPI committee monthly x 6mo. After 6 months the committee will determine the need and/or frequency of continued monitoring Date of compliance 2/23/18	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the			

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	following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no			

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	significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on interview and record review, the facility failed to ensure a resident's MDS (Minimum Data Set) assessment accurately reflected the resident's current medication regimen related to use of an anticoagulant and insulin medications for 2 of 5 residents reviewed for unnecessary medication and 1 of 2 residents reviewed for dental services. (Resident 50, 35, and 34) Findings include: 1. The clinical record review for Resident 50 was completed on 01/19/18 at 10:16 A.M. The admission MDS assessment, dated 12/19/18, indicated the resident was cognitively intact. The Resident's diagnoses included, but were not limited to, anemia, hypertension, diabetes, hip fracture, anxiety, and blindness. The MDS assessment indicated the resident received an anticoagulant medication for 0 of 7 days during the review period. Resident 50's MAR (Medication Administration Record) from December, 2017 indicated the resident received	F 0636	F636 The facility does complete accurate MDS assessments. Resident #50's 12-19-18 MDS has been modified to reflect anti-coagulant use Resident # 35's 11-25-17 MDS has been modified to the capture the 7 days of insulin injections Resident #34's 3-14-17 MDS has been modified to reflect her correct oral status at the time of assessment All residents were potentially at risk from this alleged deficient practice. The MDSC will be in-serviced by the Regional MDSC on or before Feb. 22nd, 2018, on correctly coding MDS assessment, includin g: medication classifications, oral status assessments. The Admin/AIT/DON/Designee will review 5 resident MDS assessments (their most current) weekly x 4 weeks then 5 residents a month X 5 months for accuracy. Corrective action will be taken immediately for concerned areas and assessments modified as needed. The Admin/AIT/DON/Designee will report findings to the QA/QAPI	02/23/2018

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	Lovenox, an anticoagulant medication, from 12/13/17 to 01/02/18. During an interview on 01/19/18 at 2:50 P.M., the MDS coordinator indicated Lovenox should have been marked on the admission MDS assessment as an anticoagulant administered to the resident during the review period. 2. The quarterly MDS assessment for Resident 35, dated 11/25/2017, was provided by the DON on 01/19/18 at 3:35 P.M., and reviewed at that time. The assessment indicated the resident was moderately cognitively impaired and had diagnoses including, but not limited to, hypertension, renal insufficiency, diabetes, and stroke. The medication section of the MDS assessment indicated the resident received a diuretic for 7 of 7 days during the review period. No other medications were documented as administered. The MARS for November 2017 were provided by the DON on 01/19/18 at 3:35 P.M., and reviewed at that time. The records indicated Resident 35 received insulin, Levemir, for 7 of 7 days during the review period, November 18 thru the 24, 2017. During an interview on 01/23/18 at 10:00		committee monthly x 6mo. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of compliance 2/23/18	

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	A.M. the MDS Coordinator indicated medications administered during the review period should be documented on the quarterly MDS assessments. 2. The clinical [illegible] for Resident 44 [illegible] MDS			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with			

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	the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. [illegible] The most recent Care Plan was provided by HR (Human Resources) on 01/22/18 at 04:24 P.M., and was reviewed at that time. There was no Care Plan that indicated the resident did not want CPR. During an interview on 01/24/18 at 03:33 P.M., the AIT (Administrator in Training) indicated care plans should be updated if the resident code status changed. 2. The clinical record for Resident 26 was reviewed on 01/19/18 at 01:22 P.M. The most recent comprehensive annual MDS assessment dated 08/17/17 indicated the resident was severely cognitively impaired.	F 0656	F656 The facility does develop and implement person-centered care plans which are reviewed and revised as needed Resident #17 has a current advanced directive in her chart, a care plan to match and the physician has been notified of desired code status Resident #26 has been care planned as residing on a secured unit All residents are potentially at risk from this alleged deficient practice. All resident's care plans have been reviewed to ensure accurate code status is reflected and updates have been made as needed for any resident residing	02/23/2018

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	Diagnoses included, but were not limited to, dementia. The most recent Care Plan was provided by the DON (Director of Nursing) on 01/17/18 at 03:20 P.M. and reviewed at that time. There was no Care Plan indicating the resident resided on a secure unit. During an interview on 01/24/18 at 12:03 P.M., the SSD (Social Service Director) indicated Resident 26 resided on a locked secured unit and the resident should have been care planned for residing on a locked secured unit. The facility's undated policy titled "Care Plan		on the secured unit. The MDSC and members of the IDT, will be in-serviced by the Regional MDSC on or before Feb. 22nd, 2018 on the accuracy of developing, implementing and revising, person-centered care plans. The Administrator/AIT/DON/Designee will review 5 resident care plans weekly x 4 weeks then 5 resident care plans a month X 5 months to ensure they are accurate and up to date. Corrective action will be taken immediately for concerned areas. The Administrator/AIT/DON/Designee will report findings to the QA/QAPI committee monthly x 6mo. After 6 months the committee will determine the need and/or frequency of continued monitoring Date of compliance 2/23/18	
F 0678 SS=L Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. Based on record review and interview, the facility failed to immediately initiate CPR (Cardiopulmonary Resuscitation) for a resident who was found, unresponsive,	F 0678	F678 The facility does provide CPR to all residents that desire CPR	02/23/2018

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	whose code status was unclear, and to promptly notify the physician of the resident's change in condition. This deficient practice affected 1 of 1 residents reviewed for death and 1 of 31 residents reviewed for Advance Directives. (Resident 56) The immediate jeopardy began on 11/24/17 when the facility failed to immediately initiate CPR to a resident with an unclear code status that was found unresponsive. The AIT (Administrator in Training) was notified of the immediate jeopardy on 01/22/18 at 3:18 P.M. The immediate jeopardy was removed on 1/24/18, but the non-compliance remained at the lower scope and severity level of 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During the initial process of record review on 01/18/18, it was discovered that the most recent order recapitulations (a monthly review of the resident's current orders) available for review in the resident's charts were for the month of November 2017. The recapitulations of the physician's orders for December 2017 and January 2018 were not in the charts. The AIT indicated the staff would work on gathering the orders for the		Resident #56 is deceased All residents are potentially at risk from this alleged deficient practice. All residents' charts have been audited for advanced directives, care plans for choice on advanced directive and physician notification of the advance directive. All code status wishes have a matching physician notification/order. Code status sheets were moved to the front of resident charts. Residents that have a DNR status were placed on yellow paper for a quick, visual alert. The SSD will be educated by the Admin/AIT/Designee, on offering and completing advanced directives, where to place in the resident's medical record, updating resident care plans and physician notification of resident's advance directive choices. Nursing staff will be in-serviced by the Admin/AIT/Designee on where and what to look for to determine a resident's current/accurate code status (including location in chart, MAR, Care Plan and POS). In-service will also include reporting to the SSD/DON any time a code status order is noted to be inaccurate or incomplete. Nursing staff will be in-serviced on prompt notification of a resident	

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	specific residents the surveyors requested to review, and would provide them as soon as possible. The above requested orders were provided by the DON on 01/19/18 at 2:09 P.M., and were reviewed at that time. During an interview on 01/24/18 at 10:44 A.M., the AIT indicated the previous DON had been in charge of everything related to nursing services, including handling the monthly reviews of the resident's current orders, skin assessments, and pharmacy recommendations. The previous DON had kept these documents in her office. The previous DON had fallen behind in her work but did not alert administration or ask for assistance with her duties, so it wasn't until recently that the AIT found out things hadn't been taken care of. The AIT indicated the previous DON (who is now a floor nurse) told her "She had been working all these shifts, she was tired, and she just got behind." The AIT indicated they did hire a new DON, and were working on getting things caught up. During an interview on 01/24/18 at 11:05 A.M., the Corporate Nurse Consultant indicated the monthly orders for all residents had been checked and verified for the		found to be non-responsive, have a change in condition and after hour code status changes. Corrective action will be taken immediately for concerned areas. The Admin/AIT/DON/Designee will review 5 resident records weekly x 4 weeks, then 5 resident records a month X 5 months for advanced directives, proper placement, up to date care plans and verification of physician notification. The Admin/AIT/DON/Designee will report findings to the QA/QAPI committee monthly x 6mo. After 6 months the committee will determine the need and/or frequency of continued monitoring Date of compliance 2/23/18	

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	months of December 2017 and January 2018, but they hadn't been filed into the appropriate charts. Up until recently, the previous DON had the monthly orders and pharmacy reviews in her office. The orders had been checked and verified but weren't filed appropriately. "The reason these things weren't done was a staffing issue, but they were working on getting everything back into the charts so the resident's charts were current". Resident 56's clinical record was reviewed on 01/22/18 at 10:28 A.M. The resident was found to be without cognitive impairment. Diagnoses included, but were not limited to, hypertension, congestive heart failure, diabetes, and muscular dystrophy. The most recent review of Resident 56's orders listed the resident's code status as "Full Code". The order recapitulation for the month of November 2017 was signed by the physician on 11/02/17. Resident 56's current care plans included, but were not limited to, a care plan for "Code Status, Full Code". The dates documented on the left side of the care plan indicated the care plan had been reviewed on 03/16/17, 06/15/17, 08/16/17, and 09/11/17. Interventions included, but were			

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	not limited to, "Identify the resident's chart as FULL CODE", "All staff will be made aware of the resident's choice of FULL CODE", and " In the event of cardiopulmonary arrest, initiate CPR, summon an ambulance, advise the physician [and] legal representative and transport to Emergency Room for treatment". There were no other care plans that indicated the resident had changed his code status. Review of a telephone order in a clear plastic sleeve in the resident's chart dated 01/25/17 indicated "Pt [patient] requests "No Code" status". There was a signature of the nurse that received the order, but the order was not signed by the physician. Review of a form titled "Requested Health Care Decisions" in a clear plastic sleeve in the resident's chart dated 04/18/17 indicated the resident did not want to have CPR performed as a life saving measure (i.e. "Do Not Resuscitate" "No Code"). This form was signed by the resident and a facility representative. There was no documentation on the form of the date the physician was notified. Review of a nursing progress note, dated 11/24/17 at 6:30 P.M., indicated staff went into the resident's room after a CNA			

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	(Certified Nurse Aide) reported the resident was unresponsive. The progress note indicated staff attempted to wake the resident and that he was ashen, cool to the touch, and unresponsive. Staff attempted to rouse resident verbally and with a cool wash cloth. Blood pressure was unobtainable; respiration and heart beat were absent. Review of a nursing progress note, dated 11/24/17 at 6:45 P.M., indicated "all attempts to rouse patient exhausted, res [resident] has expired". Review of a nursing progress note, dated 11/24/17 at 6:55 P.M., indicated staff attempted to call the resident's family member and left messages for family to call the facility. Review of a nursing progress note, dated 11/24/17 at 7:00 P.M., indicated staff placed a call to the mortuary to advise of Resident 56's death. Review of a nursing progress note, dated 11/24/17 at 7:10 P.M., indicated staff notified the DON (Director of Nursing), and that the DON indicated she would notify the doctor. Review of a nursing progress note, dated			

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	11/24/17 at 8:00 P.M., indicate the mortuary arrived to pick up the resident. Review of a nursing progress note, dated 11/24/17 at 9:00 P.M., indicated the resident's family member contacted the facility and was advised of the resident's passing. During an interview on 01/22/18 10:12 A.M., the DON indicated there was information in each resident's chart regarding a resident's code status. If a patient was to fall ill, the nurses were to look for the signed code status. She would look for a signed order in the front of the chart. Resident 56 had an order dated 01/25/2017 that indicated he requested to be a DNR (Do Not Resuscitate). The monthly reviewed physician orders should have been changed to reflect the resident's code status. Staff never updated the orders to reflect a DNR status. During an interview on 01/22/18 at 10:37 A.M., RN (Registered Nurse) 10 indicated she was familiar with Resident 56 and she regularly worked the hall where he resided. She was not sure but thought he was a "No Code". To find a resident's code status she would look in the MAR (Medication Administration Record) or the resident's			

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	chart. She would check the clear plastic sleeve in front of the chart. "You could check the monthly reviewed physician orders but you never knew if those were the most accurate". Review of Resident 56's most recent MAR, dated 11/01/17 through 11/30/17, listed the resident's code status as "FULL CODE". During an interview on 01/22/18 at 03:01 P.M., LPN (Licensed Practical Nurse) 7 indicated when she first went into Resident 56's room he didn't respond to her verbally and she thought that was odd. She touched him and he was cold. She assessed him; he had no pulse, no blood pressure, and was unresponsive. She did not initiate chest compressions at any time. She did not check the chart to verify his code status. She had determined the resident had already expired. During an interview on 01/22/18 at 12:32 P.M., RN 9 indicated a resident's code status should be documented in the front of the chart. If she came upon a resident that was unresponsive, she would check for a pulse, have someone check the chart for code status, and if the resident was a full code, she would start CPR and call EMS (Emergency Medical Services).			

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	During an interview on 01/23/18 at 01:56 P.M., the DON indicated Resident 56's telephone order denoting a request for a change in code status should have been faxed to the pharmacy so the code status would be changed on the monthly printout of the resident's current orders. The telephone order was incomplete because it was not signed by the physician and the "Requested Healthcare Decisions" form was incomplete because there was no documentation that indicated the physician was notified. The resident's care plans should have been updated to reflect the resident's change in code status from "Full Code" to "DNR" and they were not. The DON indicated she reviewed the resident's chart and did not find any documentation that indicated the MD was notified of the resident's change in condition. There was no documentation of a physician's order to release Resident 56's body. The current facility policy titled "Acute Condition Changes-Clinical Protocol", with a revision date of April 2009, was provided by the DON on 01/22/18 at 12:41 P.M. and was reviewed at that time. The policy indicated."...The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt			

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	response (within approximately one-half hour or less)." The current facility policy titled "Advance Directives", dated 01/2015, was provided by the AIT on 01/22/18 at 2:56 P.M. and was reviewed at that time. The policy indicated "...The facility shall comply with state law as it relates to Advance Directives ..." The current facility policy titled "Cardiopulmonary Resuscitation", with a revision date of 09/2017, was provided by the AIT on 01/22/18 at 2:07 P.M. and was reviewed at that time. The policy indicated, "...Facility staff shall provide basic life support and CPR: When cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and: ...Who do not have a valid DNR order ...If the nurse observes the resident is unresponsive but the resident's body temperature is not cold, cyanosis (bluish discoloration of the skin and mucous membranes) is not present and liver mortis (venous pooling of blood in dependent body parts) is not present, the nurse shall immediately assess circulatory and respiratory function and proceed to administer CPR, requesting emergency medical services."			

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	The Immediate Jeopardy that began on 11/24/17 was removed on 01/24/18 at 2:59 P.M., when the facility completed audits on all charts to ensure the resident's signed code status' were correct with the current physician's orders on the charts, code status sheets were moved to the front of the chart, residents that had a DNR status were placed on yellow paper to alert staff to the difference, and care plans were audited and updated to match the resident's code status. IDT (Interdisciplinary Team) staff were educated on the process of updating and changing code status. Staff had been educated on prompt notification of a resident that was found non-responsive. The non-compliance remained at the lower scope and severity level of 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had completed education on after hours code status changes and change of condition/physician notification. 3.1-4(f)(5)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent pressure ulcers for 1 of 1 resident reviewed for pressure ulcers (Resident 2). Findings include: During the survey dates of 01/18/18 to 01/24/18, Resident 2 was observed to have a scab on the outer edge of his left ear the size of a pencil eraser and dark brown in color. During an interview on 01/24/18 at 3:53 P.M., Certified Nurses Aide (CNA) 3 indicated she had informed Licensed Practical Nurse (LPN) 11 approximately two weeks ago that Resident 2 had an opened area on his left ear. During an interview on 01/24/18 at 3:59	F 0686	F686 The facility does provide treatment services to prevent/heal pressure ulcers Resident 2 had a head to toe assessment completed on wound on the ear is now being measured and has a current tx. All residents have the potential to be affected by the alleged deficient practice A facility wide skin sweep has been done to indicate if any other residents have any unknown pressure areas. Any new areas will be documented on the appropriate form, family and physician notified and new orders as indicated. Care plans and assignment sheets will be updated accordingly. Nursing staff have been in-serviced on the necessity of skin observations sheets being completed by C.N.A.s during resident showers and what to do	02/23/2018

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	P.M., Registered Nurse (RN) 13 indicated she was unaware Resident 2 had an open area on his ear. The clinical record review for Resident 2 was completed on 01/22/18 at 12:13 P.M. The annual Minimum Data Set (MDS) assessment dated 01/04/2018 indicated the resident was moderately cognitively impaired. Diagnoses include but not limited to, anemia, hypertension, benign prostatic hyperplasia, septicemia, urinary tract infection, diabetes, multiple sclerosis, anxiety, and depression. Section "M" of the annual MDS assessment indicated Resident 2 had a stage 1 pressure ulcer. The Nurses Notes and skin sheets lacked documentation indicating Resident 2 had an open area on his left ear. 3.1-40(a)(2)		with them once completed, and weekly skin assessments to be completed by licensed nurses. The in-service will also include addressing nurses receiving prompt treatment orders and the appropriate documentation when an open area has been identified. In-service completed by DON/Designee on or before Feb. 22nd, 2018 DON/Designee will audit 5 resident shower sheets and weekly skin assessments a week x 4 weeks, then 5 residents monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. Date of Completion is 2/23/18	
F 0689 SS=K Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record	F 0689	F 689	02/23/2018

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	review, the facility failed to adequately supervise residents who resided on a locked Alzheimer's Unit and had to be moved to an unsecured unit/wing. This deficient practice had the potential to affect 12 of 30 residents residing on Wing 4. (Residents 05, 07, 11, 22, 24, 26, 30, 39, 42, 44, 51, and 54) The Immediate Jeopardy began on 01/17/18 at 9:30 A.M., when there were no designated staff continually monitoring the three exit doors on Wing 4. The Administrator in Training, Corporate Clinical Compliance, Consultant, and the Director of Nursing were notified of the Immediate Jeopardy at 11:50 A.M. on 01/17/18. The Immediate Jeopardy was removed on 1/19/18, but the non-compliance remained at the lower scope and severity level of 2 of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview, on 01/16/18 at 10:54 A.M., the SSD (Social Service Director) indicated on 01/15/18 around 2:30 P.M., there was a leak in the sprinkler system in the locked Alzheimer's Unit. All residents were removed from the unit prior to the ceiling collapse. The residents were moved		The facility does maintain a resident environment that is as free of accident hazards as is possible and each resident receives supervision and assistance to prevent accidents. Resident #26 was transferred to a sister facility on 1/17/2018 that has a secured unit and returned 2/1/18 when the secured unit was reopened and is now being provided with supervision and assistance to prevent accidents. Residents #5, 7, 11, 22, 24, 26, 30, 39, 42, 44, 51, and 54 are being provided with supervision and assistance to prevent accidents. All residents at risk for elopement and/or that reside on the secured unit were at risk from this alleged deficient practice A schedule was initiated to ensure that there was someone posted at all times to do nothing but watch the doors, cords were shortened so that doors would sound if doors were slightly opened. This remained in place until the afternoon of 1/23/18 when Care Tech has finished installing alarms on both of the doors that did not have coded key pads and magnetic locks on wing 4. The doors remained on the magnetic lock key pad system until 2/1/2018. On January 31st 2018 the secured unit was reopened and all but one resident was moved back on 1/31/18. The	

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	to an unsecured unit, Wing 4. During an interview, on 01/16/18 at 11:10 A.M., the AIT (Administrator in Training) indicated the sprinkler incident was reported to the State that morning on 01/16/18 due to facility Internet not working on 01/15/18. Staff were checking all wings for fire. On 01/15/18 the AIT spoke with the night shift nurses on Wings 3 and 4. The nurses were conducting resident head counts every 15 minutes for the residents transferred to Wing 4 and would be continued until the residents were able to return to the locked Alzheimer's Unit. Staff were sitting by the exit doors of Wing 4 from 12 A.M., to 6 A.M., on 01/16/18. During an observation, on 01/16/18 at 02:47 P.M., Resident 26 exited the unsecured temporary Alzheimer's Unit (Wing 4), opening the door. The clip alarm that was attached to the door did not activate. The resident was able to open the door and walk under the clip alarm system to leave the Unit unnoticed by staff. Following the resident off of Wing 4 at 02:50 P.M., he turned right down a hallway, went to the original locked Alzheimer's Unit, stood outside the door and looked at a note that was posted to the door. The resident turned around, went to the kitchen doors,		remaining resident was moved back to the unit on 2/1/2018 All residents have an updated elopement assessment and according to the scores their care plans and assignment sheets will be updated accordingly by a member or members of the IDT. All department staff will be in-serviced by the facility Administrator/AIT/Designee on the facility elopement policy and expectations to keep identified, at risk residents, safe and free of accidentson or before Feb. 22nd, 2018. DON/Designee will audit 2 resident records a week x 4 weeks, then 2residents monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. Date of Completion is 2/23/18	

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	look at a note on the kitchen door, then turned and walked back down the hallway. The resident walked to Wing 3 where CNA (Certified Nurse Aide) 5 redirected and escorted the resident back to Wing 4 and to his room at 02:52 P.M. During an observation, on 01/16/18 at 03:01 P.M., Resident 26 exited the unsecured temporary Alzheimer's Unit (Wing 4), opening the door. The clip alarm that was attached to the door did not activate. The resident was able to open the door and walk under the clip alarm system to leave the Unit unnoticed by staff. The resident walked down the hallway and around the corner towards Wing 3. The Activities Director was walking towards the resident and redirected and escorted the resident back to Wing 4 at 3:03 P.M. The AIT, walking from the kitchen, met the resident and the Activities Director at the doors to Wing 4 and inquired of staff, "How did this happen?" During an interview, on 01/16/18 at 03:44 P.M., the AIT indicated she was aware Resident 26 was found wandering in another wing of the facility. Because the unit where the water damage occurred was the locked Dementia Unit, they had to move those residents to Wing 4 and put personal alarms			

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	on the two fire doors to alert staff if the doors were opened. Currently, Resident 26 was receiving one on one care. Going forward, staff will be stationed on the doors at all times. They will continue to do 15 minute head checks and fire checks. They will provide documentation of monitoring. During an observation, on 01/17/18 at 09:21 A.M., Resident 26 was in his room with the door closed, with no staff members present and his roommate had a visitor. There were no designated staff continually monitoring the exit doors from Wing 4. The designated chair was empty. Staff were at the nurses' station assisting other residents. During an interview, on 01/17/18 at 09:31 A.M., the AIT indicated the facility was hoping to get the Alzheimer's Unit repaired in 3 weeks or less. The facility currently had "staffing issues" and were trying to fill staff positions on the schedule. They were also trying to get volunteers to come sit at the doors on Wing 4, and "hoping to get 24 hours around the clock door coverage." An observation of Wing 4 was conducted on 01/17/18 at 09:59 A.M., DA (Dietary Aide) 4 was noted to be sitting in a chair in the middle of the hall monitoring the doors to the unit. The DM (Dietary Manager) alerted			

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	DA 4 that Resident 26, whose room was on the opposite end of the hallway, was walking alone and half way down the hall near the doors in the middle of the hallway that exited to another unit. The DM and DA 4 proceeded down the hall toward the resident. An observation of Wing 4 was conducted on 01/17/18 at 10:05 A.M. The designated chair for the continuous door observation was empty. The DA was observed talking to a resident in Room 58. The DA was inside the room and had her back to the door. The DA returned to her posted chair at 10:08 A.M. During an observation of the locked Alzheimer's Unit, on 01/17/18 at 2:48 P.M., indicated a large open area covering one third of the central hallway with bare rafters, and capped wires hanging down. The main building entrance doors located down the hall, outside of the Wing 4 fire door, were unlocked for exiting or entering the building. The record for Resident 05 was reviewed on 01/17/18 at 3:00 P.M. Diagnosis included, but was not limited to, dementia. The Annual MDS (Minimum Data Set) assessment, dated 10/10/17 indicated the resident was severely cognitively impaired			

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	and independently mobile. The resident was care planned for a secure unit related to dementia and at risk for elopement. The record for Resident 07 was reviewed on 01/17/18 at 3:02 P.M. Diagnosis included, but was not limited to, dementia. The Annual MDS assessment, dated 10/11/17 indicated the resident was independently mobile. The resident was care planned for a secure unit related to dementia, disorganized thinking, and behaviors of pacing/rummaging. The record for Resident 11 was reviewed on 01/17/18 at 3:05 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 10/18/17 indicated the resident was moderately cognitively impaired and independently mobile. The resident was care planned for a secure unit related to dementia. The record for Resident 22 was reviewed on 01/17/18 at 3:10 P.M. Diagnosis included, but was not limited to, dementia. The Significant Change MDS assessment, dated 11/13/17 indicated the resident was severely cognitively impaired and independently mobile. The resident was care planned for a secure unit related to			

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	dementia, at risk for elopement, and wondering. The record for Resident 24 was reviewed on 01/17/18 at 3:15 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 11/16/17 indicated the resident was severely cognitively impaired. The resident was care planned for a secure unit related to dementia, elopement, and wondering. The record for Resident 26 was reviewed on 01/17/18 at 3:20 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 11/17/17 indicated the resident was severely cognitively impaired and independently mobile. The resident was care planned for wondering and at risk for elopement. The record for Resident 30 was reviewed on 01/17/18 at 3:25 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 11/23/17 indicated the resident was severely cognitively impaired. The resident was care planned for a secure unit related to dementia, at risk for elopement, and wondering. The record for Resident 39 was reviewed			

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	on 01/17/18 at 3:30 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 12/01/17 indicated the resident was independently mobile. The resident was care planned for a secure unit related to dementia. The record for Resident 42 was reviewed on 01/17/18 at 3:35 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 12/08/17 indicated the resident was moderately cognitively impaired and independently mobile. The resident was care planned for a secure unit related to dementia, wondering, and at risk for elopement. The record for Resident 44 was reviewed on 01/17/18 at 3:40 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 12/13/17 indicated the resident was severely cognitively impaired and independently mobile. The resident was care planned for a secure unit related to dementia, wandering, and exit seeking. The record for Resident 51 was reviewed on 01/17/18 at 3:45 P.M. Diagnosis included, but was not limited to, dementia.			

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	The Quarterly MDS assessment, dated 12/29/17 indicated the resident was independently mobile. The resident was care planned for a secure unit related to dementia and a history of exit seeking. The record for Resident 54 was reviewed on 01/17/18 at 3:50 P.M. Diagnosis included, but was not limited to, dementia. The Quarterly MDS assessment, dated 12/14/17 indicated the resident was independently mobile. The resident was care planned for a secure unit related to dementia, wandering, restlessness, and at risk for elopement. The current facility policy titled " Abuse and Neglect", with a revision date of April 2007, was provided on 01/16/18 and was reviewed at that time. The policy indicated, "...Along with other staff and management, the Medical Director will help identify situations that might constitute or could be construed as neglect: for example, ...inappropriate management of problematic behavior...The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect..." The current facility policy titled "Elopement (Missing/Wandering Residents)", dated			

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	October 2014, was provided on 01/24/18 at 4:06 P.M. and was reviewed at that time. The policy indicated, "...ensure a secure environment for residents at risk for elopement..." The Immediate Jeopardy that began on 01/17/18 at 09:30 A.M. was removed on 01/19/18 at 04:10 P.M. when the facility inserviced staff from all departments on 01/17/18 on the expectations when assigned to being a door monitor on Wing 4 (temporary residence for residents from secured unit) .15 minute checks were in place for all residents that previously resided on the secured unit, a binder had been placed at the nurse's station on Wing 4 with pictures of all the residents that previously resided on the secure unit so all staff will know who the residents from the secured wing were. The non-compliance remained at the lower scope and severity level of 2, no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facility was attempting to find a vendor to place key pads on both sides of the two fire doors on Wing 4 to secure the area without the need for a constant door monitor. 3.1-45(a)(2)			

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F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure there was sufficient staff on 1 of 2 nursing units to meet the needs of residents related to bathing and toileting. This deficient practice effected 1 of 1 residents reviewed for choices (Resident 34), and 1 of 1 resident reviewed for activities of daily living (Resident 53). This	F 0725	F 725 The facility does employee sufficient staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident Resident # 53 has been	02/23/2018

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	deficient practice had the potential to affect 33 of 52 residents residing in the facility. Findings include: 1. During the survey, there were 33 residents on Wing 3, 10 that required 2 person assist for transfers, 19 that had episodes of incontinence, 22 that were high risk for falls, and 26 that were in wheelchairs. The staffing schedule, for 01/19/18 indicated there was only one CNA (Certified Nurse Aide) assigned to Wing 3 for the day shift. During an interview on 01/17/18 at 09:31 A.M. the AIT indicated the facility was having "staffing issues." During an interview on 01/22/18 at 02:18 P.M., CNA (Certified Nurse Aide) 8 indicated she had worked dayshift on Wing 3 before she resigned from the facility. She was regularly scheduled to work the wing by herself. She did not feel like she could provide adequate care to the residents without more help. 2. During an interview on 01/19/18 at 10:51 A.M., Resident 53, while laying in bed, indicated he had used his call light to get help following a bowel movement at 08:00		discharged per his choice to be closer to family Resident 34 has been given a shower and will continue to receive showers routinely Any resident has the potential to be affected by this alleged, deficient practice. Nursing staff will be in-serviced by the Administrator/AIT/DON/or Designee, on or before Feb. 22nd, 2018, regarding resident rights and providing dignity with an emphasis on prompt toileting and incontinent care as well as providing showers as scheduled. All departments will be in-serviced by the Administrator/AIT on answering call-lights in a timely manner on or before Feb. 22nd, 2018. A minimal nursing staffing pattern has been determined for each unit and each shift. Managers and Administrator were educated by the Regional Clinical Director on 2/7/2018 that every effort must be made to ensure holes and or / call-ins that make them below that minimum staffing pattern, be covered including the weekends. The DON/Designee will observe/interview 5 residents a week X 4 weeks, then 5 residents a month X 5 months to ensure	

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	A.M.. Staff told him they, "would get to him when they could get to him." Staff had not been back in his room since 08:00 A.M. and he had been sitting in his own stool since that time. During an observation at the Nurse's Station on Wing 3 on 01/19/18 at 10:54 A.M., Resident 53 activated his call light and RN (Registered Nurse) 12 entered his room. At 10:56 AM the nurse was observed while providing incontinence care for the resident. As the nurse, wearing gloves, removed the resident's brief, dried caked on feces was noted reaching up to two inches below his navel on his abdomen, on the outside of his brief, on his gown, on the bedspread, on the call light, on top of the resident's left thigh, in the center of his chest, and totally encompassing the resident's peri anal area. The clinical record for Resident 53 was reviewed on 01/22/18 at 10:22 A.M. A quarterly MDS assessment, dated 12-12-17, indicated the resident was cognitively intact, needed extensive assistance of two staff for personal hygiene, was always incontinent of urine, and frequently incontinent of bowel. Diagnoses included, but were not limited to, Multiple Sclerosis. 3. The clinical record for Resident 34 was		resident needs are being met. Corrective action will be taken immediately on any area of concern. DON/Designee will audit residents shower sheets weekly and interview residents to ensure that they have received their showers as scheduled. The DON will review staffing daily with the Administrator or AIT during the Daily Morning Meeting. The DON/Designee will report findings to the QA/QAPI committee monthly x 6mo. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of compliance: 2/23/18	

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	reviewed on 01/22/18 at 11:14 A.M. The most recent admission MDS assessment dated 03/14/17 indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, hypertension, diabetes, and dementia. The resident needed physical assistance with part of her bathing. During an interview on 01/18/18 at 10:43 A.M., Resident 34 indicated on 11/24/17, the day after Thanksgiving, there was only one aide working and no one got their showers that day. She had an appointment that following Monday and went to the appointment "smelling like a dirty little piggy", and it happens quite often. The Wing 3 CNA Assignment Sheet was provided by RN 10 on 01/22/18 at 4:07 P.M. and was reviewed at that time. The CNA sheet indicated Resident 34 was scheduled to receive her showers during the dayshift on Tuesdays and Fridays. During an interview on 01/23/18 at 2:57 P.M., CNA 17 indicated Resident 34 was compliant with care, always took her showers, and needed assistance with showers. During an interview on 01/24/18 at 11:33			

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	A.M., CNA 17 indicated she documented showers on the CNA sheets. On 01/24/18 at 11:38 A.M. Resident 34's Resident Care Record/CNA sheets were reviewed. The sheets lacked documentation for showers on 11/10/17, 11/17/17, and 11/24/17. The progress notes lacked documentation the resident refused/ did not receive a shower for the above dates. During an interview on 01/24/18 at 02:30 P.M., the Corporate MDS Coordinator indicated if the showers were not documented then they were not done and was unable to locate skin sheets that the CNA's filled out when a shower was given for the dates 11/10/17, 11/17/17, and 11/24/17. During an interview on 01/24/18 at 02:30 P.M., the MDS Coordinator indicated if a resident refused a shower three times then she would notify the family and was unaware of Resident 34 refusing her showers. During an interview on 01/24/18 at 03:05 P.M., CNA 18 indicated she documented showers on a shower sheet and CNA sheet and turn them into the Director. If the shower spot is left blank on the CNA sheet it would mean the resident didn't get their			

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	shower. Resident's wouldn't get showers if there was only one aide on the hall. 3.1-17(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record [illegible]	F 0761	F 761 It is the practice of the facility to keep medications safely stored	02/23/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			No residents were identified All residents have the potential to be affected by the alleged deficient practice. All carts are now locked when unattended Department Managers were educated by the DON on 2/13/18 that when making rounds to check that the carts are locked and to push the lock in if the cart is unattended. Findings are then to be reported to the DON/Designee at the time of occurrence. Nurses and/or QMAs that have access to utilize medication carts wereeducated by DON on 2/13/18 on ensuring that medication and treatment carts remain locked at all times when they are not in use and/or unattended. Administrator/AIT/DON/Designee will audit all carts 5 times a week x 4 weeks, then 5 times monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of Completion is 2/23/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	01/24/2018

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to follow appropriate food storage guidelines for 2 of 2 snack refrigerators reviewed related to food labeling and expired foods. This deficient practice affected 1 of 55 residents that resided in the facility and were permitted to use the snack refrigerator. (Resident 9) Findings Include:	F 0812	F 812 It is the practice of the facility to practice sanitary food storage All resident pantry storage refrigerators have been cleaned and opened food items are now dated. Staff no longer keep personal food items in the storage refrigerators. All residents have the potential to be affected by the alleged deficient practice Staff were in-serviced by DON on 2/13/17 about the new refrigerator cleaning schedule and who is	02/23/2018

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	The snack refrigerator located on Wing 4 was observed with Licensed Practical Nurse (LPN) 11 on 01/16/18 at 10:58 A.M. On the top shelf of the refrigerator door was a four inch circle of chocolate syrup. On the second shelf there was an eight ounce Daisy Light Sour Cream container with Resident 9's name and dated "12/27/17", inside was a cheese ball covered with nuts. On the bottom shelf were two 32 ounce containers of thickened prune juice one dated "1/5/18", and the other dated "1/7/18". LPN 11 indicated the food and juice were outdated and placed the containers in the trash. The snack refrigerator located on Wing 3 was observed with Registered Nurse (RN) 12 on 01/16/18 at 11:05 A.M. In the bottom right crisper drawer was a 32 ounce container of vanilla yogurt and a plastic container of fruit with no name or date. RN 12 indicated the containers were probably someone's lunch and removed them from the snack refrigerator. During an interview on 01/24/18 at 2:14 P.M., the Dietary Manager (DM) indicated all items should have been labeled with the residents' initials and dated when received. Opened items in the kitchen are kept for 3 days then discarded if not consumed. It is the responsibility of the nursing staff on the		responsible. Staff has also been educated on this is storage for residents only as well as ensuring opened items are dated and that expired items are disposed of immediately when indicated. Administrator/Housekeeping Supervisor and/or designee will audit the refrigerators 5 days a week X 4 weeks then 5 X monthly X 5 months Corrective actions will be taken immediately of any concern. Administrator/ Housekeeping Supervisor and/or Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of Completion is 2/23/28	

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	wings to keep the snack refrigerators cleaned. The current "Refrigerated Foods/Nourishment Pantries" Policy, with a date of 10/2014, was provided by the Administrator in Training on 01/24/18 at 1:48 P.M., and reviewed at that time. The policy indicated, "...It is the policy of this facility to date mark all food items when opened...Food items that require refrigeration shall be maintained for 3 days...No employee food items should be stored with resident's nourishments...Juice maximum storage 7 days opened..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the			

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	facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.			

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	§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview, record review, and observations, the facility failed to have complete documentation for Neurological Assessments following a fall, medication administration, and wound care. This deficient practice affected 1 of 3 residents reviewed for accidents, 1 of 5 residents reviewed for unnecessary medications, and 1 of 1 residents reviewed for pressure ulcers. (Residents 35, 14, and 2) Findings include: 1. During an interview on 01/18/18 at 09:40 A.M. Resident 35 indicated he had fallen out of bed a couple of weeks ago and had hit his head. The quarterly MDS (Minimum Data Set) assessment for Resident 35, dated	F 0842	F842 It is the practice of the facility to maintain accurate, complete records Resident #35 fall risk assessment and care plan has been updated and will receive follow up care, per facility policy, after any future fall. Resident #14 now receives medications and vital signs as indicated and/or ordered with proper documentation Resident 2 had a head to toe assessment completed on , wound on the ear is now being measured and has a current tx. All residents have the potential for being affected by the alleged deficient practice A facility wide skin sweep has been done to indicate if any other residents have any unknown pressure areas. Any new areas will be documented on the	02/23/2018

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	11/25/17, was provided by the DON (Director of Nursing) on 01/19/18 at 3:35 P.M. and reviewed at that time. The assessment indicated the resident was moderately cognitively impaired and had diagnoses including, but were not limited to, dementia, hypertension, renal insufficiency, diabetes, Parkinson's disease, and stroke. The Nurse's Notes, dated 08/20/17 at 06:30 P.M., indicated Resident 35 was found on the floor in his room by another resident at 06:15 P.M. The resident's head was touching the floor with his lower extremities still in the bed. The resident stated he had hit his head. Neurological Checks (Assessments) were started. Nurse's Notes dated 08/23/17 at 11:00 A.M. and 08/24/17 at 10:00 A.M. indicated the resident's Neurological Checks were normal. No other Neurological Checks were found in the Clinical Record. During an interview on 01/23/18 at 12:20 P.M. the AIT (Administrator in Training) indicated they could not locate the "Accident & Incident Report and Investigation" nor the "Neurological Check Flowsheet" that should have been completed following the resident's fall on 08//20/17 at 6:15 P.M.		appropriate form, family and physician notified and new orders as indicated. Care plans and assignment sheets will be updated accordingly. Nursing staff have been in-serviced on the necessity of skin observationsheets being completed by C.N.A.s during resident showers and what to do with them once completed, and weekly skin assessments to be completed by licensed nurses. The in-service will also include addressing nurses receiving prompt treatment orders and the appropriate documentation when an open area has been identified. In-service will be completed by DON/Designee, on or before Feb. 22nd, 2018. Licensed Nurses will be in-serviced on the facility fall and Neuro check policy by the DON/Designee on 2/13/2018. Licensed Nurses and QMAshave been educated on following the MAR for administration of medications and specific vitals signs that are to be obtained, including documentation. DON/Designee will audit 5 resident shower sheets and weekly skin assessments a week x 4 weeks, then 5 residents monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will audit 5 residents MARs a week x 4	

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	During an interview on 01/24/18 at 04:02 P.M., the AIT indicated following an unwitnessed fall or a fall where a resident had hit their head the staff should complete facility forms that included, but were not limited to, the "Post Fall Investigation", the "Neurologic Check Flowsheet", and the "Fall Prevention Resident Environment Safety Inspection". The current "Fall Emergency, First Aid" policy, dated 10/2014, was provided by the AIT on 01/24/18 at 01:48 P.M. and reviewed at that time. The policy indicated, "...Any resident who sustains a fall...Assess for injury to head. If noted, begin neurologic checks immediately..." The current "Fall Prevention Program" policy, dated 10/2014, was provided by the AIT on 01/24/18 at 01:48 P.M. and reviewed at that time. The policy indicated, "... Should a resident incur a fall, the licensed personnel will complete an Accident/Incident Report AND POST FALL INVESTIGATION..." The current "Neurological Assessment" policy, dated 10/2014, was provided by the AIT on 01/24/18 at 01:48 P.M. and reviewed at that time. The policy indicated, "...Neurological assessment, is to be		weeks, then 5 residents MARs monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of Completion is 2/23/18	

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	completed in all cases of head injury to the resident (when suspected or known) at the following frequency: every 15 minutes X 1 hour; every hour X 4 hours; every 4 hours X 72 hours; daily X 7 days..." 2. The clinical record for Resident 14 was reviewed on 01/22/18 at 10:47 A.M. The most recent admission MDS assessment dated 07/21/17, indicated the resident was severely cognitively impaired. Diagnoses included, but were not limited to, dementia, pain, hypertension, and major depressive disorder. The resident was receiving hospice care. The MAR (Medication Administration Record) dated January 2018 for Resident 14 was provided by the DON on 01/19/18 and was reviewed at that time. The MAR lacked documentation indicating Resident 14 received medications for the following dates and times: Ativan and Norco at 03:00 PM and 07:00 PM on 01/01/18 and 01/02/18, Coreg at 05:00 PM on 01/02/18, Depakene at 05:00 PM on 01/01/18 and 01/02/18, and UTI-STAT Liquid at 05:00 PM on 01/01/18 and 01//02/18. The MAR contained a physician's order, dated 07/14/17 for Coreg 3.125 mg (milligram) tablet. Give 1/2 tab (tablet) by			

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	mouth 2 times a day for diagnoses of hypertension. Check heart rate. If less than 50 hold and notify physician. The MAR lacked documentation that a heart rate was obtained at 11:00 AM on 01/02/18 and 01/03/18 and at 05:00 PM on 01/03/18. No progress notes indicated why the medications or heart rate were not documented. During an interview on 01/24/18 at 3:47 P.M., the MDS Coordinator indicated if medications were not signed on the MAR that would indicate the medications were not given. If a medication needed a heart rate obtained prior to administration the it should have been documented on the MAR. There was no documentation on the MAR or in the progress notes pertaining to why the resident did not receive the medications. The current facility policy titled "Medication Administration" was provided by the Corporate MDS Coordinator on 01/24/18 at 04:09 P.M., and was reviewed at that time. The policy indicated, "...Always take pulse..as indicated if ordered prior to giving certain...antihypertensive drugs...Always record the dose of medication on the MAR			

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	after resident consumption..."3. During the survey dates of 01/18/18 to 01/24/18, Resident 2 was observed to have a scab on the outer edge of his left ear the size of a pencil eraser and dark brown in color. During an interview on 01/24/18 at 3:53 P.M., Certified Nurses Aide (CNA) 3 indicated she had informed Licensed Practical Nurse (LPN) 11 approximately two weeks ago that Resident 2 had an opened area on his left ear. During an interview on 01/24/18 at 3:59 P.M., Registered Nurse (RN) 13 indicated she was unaware Resident 2 had an open area on his ear. The clinical record review for Resident 2 was completed on 01/22/18 at 12:13 P.M. The annual Minimum Data Set (MDS) assessment dated 01/04/2018 indicated the resident was moderately cognitively impaired. Diagnoses include but not limited to, anemia, hypertension, benign prostatic hyperplasia, septicemia, urinary tract infection, diabetes, multiple sclerosis, anxiety, and depression. Section "M" of the annual MDS assessment indicated Resident 2 had a stage 1 pressure ulcer. The Nurses Notes and skin sheets lacked documentation indicating Resident 2 had an open area on			

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	his left ear. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record	F 0880		02/23/2018

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	review, the facility failed to follow transmission based precautions for 1 of 2 residents reviewed for isolation precautions (Resident 37), and for 1 of 1 residents reviewed for incontinence care (Resident 53). Findings include: 1. During a continuous observation on 01/17/18 from 02:56 P.M. to 3:05 P.M., RN (Registered Nurse) 13 entered Resident 37's room, who was in contact isolation, placed a piece of paper on the resident's bedside table, and asked the resident if she could assess his vital signs. RN 13 placed a tympanic (ear) thermometer in the resident's ear, assessed his temperature, removed the plastic cover from the thermometer probe, and disposed of the probe cover. She then applied a digital blood pressure cuff to the resident's right arm, obtained his blood pressure, removed the cuff, and placed it on the table. She documented the resident's vital signs on the paper, gathered the paper, thermometer, and blood pressure cuff, and went into the resident's bathroom. She exited the bathroom using the door that entered into another resident's room and exited that room and went into the hallway. RN 13 was not wearing an isolation gown or gloves at any time during this observation.		F 880 The facility does now follow transmission based precautions Resident #37 is no longer on contact precautions Resident# 53 Has been discharged to a sister facility to be closer to family All residents have the potential to be affected by the alleged deficient practice Separate vital sign equipment has been designated for use only on residents that have infection that is possible to be spread beyond what universal precautions do not cover. All staff have been in-serviced on hand washing, universal and contact precautions, and glove changes. Nursing staff have been educated on peri-care and glove changes. In-service completed by DON/Designee on 2/13/18 The DON has been educated on maintaining the infection control log by the Regional Clinical Director on 2/7/18. DON/Designee will audit 5 employees a week x 4 weeks, then 5 employees monthly X 5 months. Corrective actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. The Administrator and/or designee will audit the Infection control logs weekly X 4 and then monthly X 5 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 01/17/18 at 3:05 P.M., RN 13 indicated Resident 37 was on contact isolation precautions for MRSA (Methicillin-resistant Staphylococcus aureus) in his urine. She should have put on gloves before she provided care for the resident. They did not normally have dedicated equipment for each resident that was on isolation precautions, they used the same equipment for everyone. She indicated she cleaned the thermometer with an alcohol swab but she did not clean the blood pressure cuff. "Part of the cuff that came into contact with the resident's skin was cloth, and I don't know how I could clean it". Resident 37's clinical record was reviewed on 01/24/18 at 4:00 P.M. An admission MDS (minimum data set) assessment, dated 12/05/17, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, hypertension, diabetes, and depression. Review of a telephone order, dated 01/11/18, indicated Resident 37 was to be placed in contact isolation due to urinalysis results. The current facility policy titled "Isolation (Transmission-Based Precautions)		Administrator/Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of Completion is 2/23/18	

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	155208	A. BUILDING 00 B. WING	01/24/2018

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	Guidelines", dated 10/2015, was provided by the AIT (Administrator in Training) on 01/24/18 at 1:48 P.M. and was reviewed at that time. The policy indicated " ...Non-disposable contaminated items must be...decontaminated on site...All personnel must follow transmission-based precautions as indicated..." 2. During an interview on 01/16/18 at 03:34 P.M., Resident 53 indicated he did not get the help he needed going to the bathroom. When he activated his call light and asked for assistance to the bathroom, staff would tell him to go on himself and they would clean it up later. With the assistance of two people he could transfer to the toilet. During an interview on 01/19/18 at 10:51 A.M., Resident 53, while laying in bed, indicated he had used his call light to get help following a bowel movement at 08:00 AM. Staff told him they "Would get to him when they could get to him." Staff had not been back in his room since 08:00 AM and he had been sitting in his own stool since that time. During an observation at the Nurse's Station on Wing 3 on 01/19/18 at 10:54 A.M., Resident 53 activated his call light and RN 12 entered his room. At 10:56 A.M. the nurse was observed while providing			

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	incontinence care for the resident. As the nurse, wearing gloves, removed the resident's brief, dried, caked on feces was noted reaching up to two inches below his navel on his abdomen, on the outside of his brief, on his gown, on the bedspread, on the call light, on top of the resident's left thigh, in the center of his chest, and totally encompassing the resident's peri anal area. The room smelled strongly of bowel movement. The resident's gown was placed in a plastic bag. The nurse, wearing gloves, cleaned the resident using soapy washcloths. The dirty bed pad was rolled up and tucked under the resident's back followed by a clean bed pad. The nurse changed gloves, got a clean brief, then got feces on the clean brief when placing it under the resident. Without changing gloves, the nurse opened a new bag of briefs and retrieved one. She removed the soiled brief, placed the new one under the resident as he was rolled on his left side, rolled the resident on his back, attached the brief on the resident's right side, rolled the resident toward her, removed the soiled bed pad, unrolled the clean bed pad, and attached the brief on the resident's left side. The nurse bagged the soiled items, removed her gloves, retrieved clean clothes for the resident, applied deodorant to the resident, then assisted the resident with a			

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	shirt and pants. The nurse went into the bathroom, donned clean gloves, retrieved more wash cloths, cleaned off the call light, bagged the dirty laundry, and removed her gloves. The nurse went into the bathroom, washed her hands, shut the water off with a clean paper towel, disposed of it, then dried her hands with more clean paper towels. The nurse went into the hall, retrieved fresh bed linens, donned gloves, changed the bedding, bagged the dirty linens, removed her gloves, placed a clean sheet and blanket over the resident, tied up the trash, double bagged the dirty linens, then exited the room. During an interview on 01/23/18 at 12:04 P.M., RN 10 indicated when providing incontinence care following a bowel movement, after the fecal matter was cleaned up she would remove her gloves, wash her hands, and don clean gloves before assisting a resident with clean clothing and linens. During an interview on 01/23/18 at 01:50 P.M., CNA (Certified Nurse Aide) 14 indicated Resident 53 was alert and able to use his call light when he needed assistance. The clinical record for Resident 53 was reviewed on 01/22/18 at 10:22 A.M.. A			

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	quarterly MDS assessment, dated 12-12-17, indicated the resident was cognitively intact, needed extensive assistance of two staff for personal hygiene, was always incontinent of urine, and frequently incontinent of bowel. Diagnoses included, but were not limited to, Multiple Sclerosis. The current "Perineal Care" policy, dated 10/2014, was provided by the AIT on 01/24/18 at 1:48 P.M. and reviewed at that time. The policy indicated, "...Put on gloves...Wipe from front to back...rinse area..pat dry...Assist resident to lateral position facing away from you...Clean anal area...remove gloves. Wash hands...Assist resident to replace clothing..." The current "Handwashing / Hand Hygiene" policy, dated 10/2014, was provided by the AIT on 01/24/18 at 1:48 P.M. and reviewed at that time. The policy indicated,...Situations that require hand hygiene include, but are not limited to:...Before and after assisting a resident with personal care..after handling soiled or used linens...after removing gloves..." The handwashing procedure indicated after washing hands with soap to, "...Rinse hands...Dry hands thoroughly with a single use towel...Use towel to turn off faucet..."			

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	3. The tracking and trending "Infection Monitoring Log" for November 2017 was provided by the AIT on 01/23/18 at 4:07 P.M. and reviewed at that time. The records indicated 4 residents were treated for infections with antibiotics. No logs were noted for December 2017 or January 2018. During an interview on 01/23/18 at 04:05 P.M. the DON (Director of Nursing) indicated there was no documentation for infection monitoring for December 2017 or January 2018 and no logs were completed. 3.1-18(a) 3.1-18(l) 3.1-18(b)(1)(A)			
F 0881 SS=F Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure an Antibiotic	F 0881	F 881 It is the practice of the facility to	02/23/2018

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	Stewardship Policy and Program was put in place for 2 of 2 months reviewed for antibiotic use. This had the potential to effect 55 of 55 residents residing in the facility. Findings include: The tracking and trending "Infection Monitoring Log" for November 2017 was provided by the AIT (Administrator in Training) on 01/23/18 at 4:07 PM, and reviewed at that time. The records indicated four residents were treated for infections with antibiotics. No logs were noted for December 2017 or January 2018. During an interview on 01/23/18 at 04:05 PM, the DON (Director of Nursing) indicated there was no documentation for infection monitoring for December 2017 or January 2018 and no logs were completed. There was no documentation of the implementation of the Antibiotic Stewardship compliance tool for infections or discussion with the physician related to antibiotic use. During an interview on 01/18/18 at 01:54 PM, the DON indicated she did not know if the facility had an Antibiotic Stewardship Program in place before Chosen (the new		provide infection control and prevention in conjunction with the Antibiotic stewardship program. No residents were identified All residents have the potential to be affected by the alleged deficient practice An Antibiotic Stewardship program has been put into place. There has been a binder placed at all the units Staff has been educated on the antibiotic stewardship, including the DON, who will be responsible to ensure the Antibiotic Stewardship Program is actively functioning and remains up to date by the Regional Clinical Director on 2/7/18. Physicians' have been informed of the facility Antibiotic Stewardship program. The DON and Administrator/AIT will discuss the ABT Stewardship Program weekly x 1 mo after implementation, in the daily morning meeting and then monthly x 5 months to ensure the program remains active and up to date. DON/Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of Compliance 2/23/18	

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	owners) took over. Chosen was only able to get into the building on January 1, 2018. The infection tracking/trending documentation was all she could find. They do not currently have an Antibiotic Stewardship policy/procedure or program in place.			
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee completed the appropriate number of	F 9999	F9999 It is the practice of the facility to provide personnel with the appropriate amount of dementia training. No residents were identified in the alleged deficient practice All current staff have a minimum of 6 hours of dementia training and will receive at least 3 hours of additional dementia training annually. New employees will receive an initial Dementia Training at the time of hire, and then will receive 6 additional hours within 6 months of employment or within 30 days if specifically assigned to care for residents on the secured unit. HR and/or designee will audit 5 employees records a week X 4 weeks then 5 employee records monthly X 5 months to ensure that dementia training is up to date for all employees.	02/23/2018

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	dementia training hours in a timely manner. This affected 7 of 10 staff members reviewed for employee records. (Registered Nurse [RN] 16, Licensed Practical Nurse [LPN]11, Certified Nurse Aide [CNA] 5, CNA 14, Dietary Aide 4, Transport Aide 19, House keeper 20) Findings include: Employee records were provided by the Human Resources on 01/23/2018 at 9:50 A.M. and reviewed at that time. 1. RN 16 was hired on 03/05/2014. Her employee file lacked any documentation of dementia training. 2. LPN 11 was hired on 04/01/2005. Her employee file lacked any documentation of dementia training. 3. CNA 5 was hired 05/03/2017. His employee file lacked any documentation of dementia training. 4. CNA 14 was hired on 09/20/2017. Her employee file lacked any documentation of dementia training. 5. Dietary Aide 4 was hired on 06/21/2017. Her employee file lacked any		HR/Designee will report the findings to the QA/QAPI committee meeting X 6months. After 6 month the committee will determine the need and/or frequency of continued monitoring. Date of compliance 2/23/2018	

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	documentation of dementia training. 6. Transport Aide 19 was hired on 06/25/2014. His employee file lacked any documentation of dementia training. 7. House keeper 20 was hired on 09/09/2012. His employee file lacked any documentation of dementia training. During an interview on 01/23/18 at 9:42 A.M., the Director of Nursing indicated she had given the HR everything she had on dementia training. The current "In-service Requirements Comprehensive Licensure" policy, with a date of 1/2015, was provided the Administrator in Training on 01/24/18 at 3:47 P.M., and was reviewed at that time. "...(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of			

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	care for residents with dementia..."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 16, 17, 18, 19, 22, 23 and 24, 2018 Facility number: 000115 Residential Census: 08 Hanover Nursing Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on January 30, 2018	R 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 23rd 2018 for the annual licensure survey conducted on January 16th, 2018 through January 24th, 2018.	