STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey - Substandard Quality of Care. This visit was in conjunction with the Investigation of Complaint IN00185775. Survey dates: October 26, 27, 28, 29 and 30, 2015 Extended Survey dates: November 2 & 4, 2015 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census bed type: SNF/NF: 53 Total: 53 Census payor type: Medicare: 3 Medicaid: 43 Other: 7 Total: 53 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	QR completed by 14454 on November 12, 2015.			
F 0156 SS=B Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of			

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

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	The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interviews, the facility failed to ensure a resident receiving Medicaid received a list of services and items that the resident would and would not be charged for 1 of 3 residents reviewed for personal funds. (Resident #59) Finding includes: On 10/29/15 at 9:38 A.M., record review indicated Resident #59 was admitted to the facility on 7/29/13. The primary payor source was Medicaid. During an interview, on 10/28/15 at 9:35 A.M., Resident 59's Power of Attorney (POA) indicated she did not receive a list of services and items that she would and would not be charged for. During an interview, on 10/29/15 at 9:00 A.M., Employee # 11 indicated he was new to the Admission Director position and did not recall a list in the admission packet explaining Medicaid covered	F 0156	**F156 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation ofcompliance. Preparation and/or execution of this plan of correction does notconstitute admission or agreement by the provider of the truth of the factsalleged or conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident # 59 The Responsible Party was given a copy of the list of servicesand items that the resident would and would not be charged for. **2) How the facility identified other residents:** An audit was conducted of all admission files to identify otherresidents affected. A copy of the listof services and items that the resident would and would not be charged for willbe provided to all residents or responsible parties for those identified. **3) Measures put into place/ System changes:**	12/04/2015

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	services and items. During an interview, on 10/29/15 at 9:20 A.M., the Minimum Data Set (MDS) Coordinator/Case Manager, indicated there was a section in the resident move in agreement which indicated a list of non-covered items could be found in the Resident Move in Guide. The MDS Coordinator and Employee #11 were unable to locate the information in the resident move in guide. The MDS Coordinator further indicated it is not something that is given to families or residents during the admission process. On 10/29/15 at 10:49 A.M., review of the undated current policy titled, "Charges to Personal Funds," received from the MDS Coordinator indicated "...The facility will not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services...." 3.1-4(f)(1)(A) 3.1-4(f)(1)(B)		List of services and items that theresident would and would not be charged for was added to the admission packetto be given to all new admissions. **4) How the corrective actions will be monitored:** The Administrator or designee will audit new admissions as they occur weekly toverify that the list of services and items that the resident would and wouldnot be charged for are present in the admission packet. The results of these audits will be reviewed in Quality AssuranceMeeting monthly until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 12/4/15**	

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F 0160 SS=B Bldg. 00	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on record review and interview, the facility failed to ensure residents funds was conveyed timely upon death for 2 of 3 resident fund accounts reviewed. (Resident #3 and Resident #71). Finding includes: On 10/29/15 at 10:45 A.M., personal funds accounts were reviewed with the Business Office Manager (BOM). A resident statement, dated 10/29/15, indicated Resident #3 passed away on 7/17/15 and as of 9/1/15 Resident #3 had a remaining balance of $10.00 in the personal fund account. An interview at this time with the BOM indicated, when Resident #3 passed away her husband still resided in the facility and it was the families wish for the BOM to transfer the remaining funds into his account for use. The BOM further indicated she did not transfer the funds into the husbands	F 0160	**F 160** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #3 funds were dispersedon 9/1/15. Resident #71 funds weredispersed on 11/18/15. **1. How the facility identified other resident:** A complete audit was conductedby the Business Office Manager of personal funds of residents who have expired or discharged from the facility. **1. Measures put into**	12/04/2015

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	account and refunded the family the $10.00, on 9/1/15, after husband passed away. During an interview, on 10/29/15 at 11:10 A.M., the BOM indicated Resident #71 expired on 8/31/15. A Resident Statement for Resident 71, dated 10/29/15, indicated Resident 71's personal fund account had a current balance of $156.02 as of 10/29/15. On 10/29/15 at 12:45 P.M., review of the undated current policy titled, "Refunds of Deposits, Personal Funds, Prepayments, or Overpayments," received from the Business Office Manager, indicated "...Any resident personal funds, valuables, deposits, prepayments, or overpayments held by the facility will be refunded within thirty (30) days after deductions for payment of any amounts due to the facility after the resident 's discharge. In the event of the resident 's death, such refund or return will be made to the authorized representative of the resident's estate. If the resident is a Medicaid recipient in the state of Indiana, the Indiana Medicaid guidelines states any monies remaining in the resident trust account upon their death must be refunded to the county in which they have resided...."		**place/systems changes:** Upon completing daily censusit will be noted if a discharged or expired resident has a resident account. On the last day of the monthall discharged residents will be reviewed for funds and refunded or transferredto care cost if necessary. **1. How the corrective actions will be monitored:** The Business Office Managerwill review each discharge/expired resident monthly and place findings on andaudit tool. Results of the audit will besubmitted to the Administrator and be reviewed in Quality Assurance monthly until100% compliance is achieved x3 consecutive months. **1. Date of compliance:** **12/4/15**	

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	3.1-6(h)			
F 0203 SS=D Bldg. 00	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason			

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	for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on record review and interview, the facility failed to ensure a resident was given written transfer notification from the facility. (Resident #7) Finding includes: On 10/30/15 at 3:50 P.M., a review of the clinical record for Resident #7 was conducted. Resident #7 was admitted on 8/25/14. The resident's diagnoses included but were not limited to, heart failure, chronic obstructive airway disease, cirrhosis of the liver and bipolar. The resident's status on the chart	F 0203	**F 203** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #7 was transferred toan acute care psychiatric facility for	12/04/2015

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	indicated he was discharged from the facility on 10/20/15. During an interview, on 11/2/15 at 9:45 A.M., the Social Service Director (SSD) indicated the resident had threatened another resident and the other resident was feeling afraid. The SSD indicated the resident had been noncompliant regarding the smoking policy and signing himself out AMA (Against Medical Advice) to smoke off the property. The SSD further indicated the resident had an order from his physician to sign himself out AMA and go off property to smoke. The SSD indicated on 10/20/15, Resident #7 had been approached about a transfer to a local psychiatric hospital and he agreed to be transferred to the facility. Resident was his own responsible party. The SSD further indicated the resident would not be allowed to re-enter the facility. The SSD indicated the resident had not be given notice of the discharge due to Resident was admitted to a local psychiatric hospital. On 11/2/15 at 4:15 P.M., the SSD provided a policy titled "Discharge Procedures," dated 1/2012, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Obtain a physician's order... 2. Print and complete the "Transfer/Discharge		evaluation and treatment of uncontrolledbehaviors. **1. How the facility identified other resident:** An audit was completed of alldischarged residents in the last 30 days. No other residents were identified that required notice be given. Alldischarges were either to an acute care setting, planned/voluntary dischargehome, or expired. **1. Measures put into place/systems changes:** All discharges will bereviewed as they occur to identify if discharge was voluntary or involuntary.Any involuntary discharges will be reviewed to ensure appropriate notice ofdischarge was provided prior to discharge as required. **1. How the corrective actions will be monitored:** The Administrator or designeewill be responsible for oversight of these audits. The results of these auditswill be reviewed in Quality Assurance Meeting monthly until 100% compliance isachieved x3 consecutive months. **1. Date of compliance:** **12-4-15**	

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	Record" in layman's terms. Send the original with the resident, and maintain a copy in the resident's current overflow file...." 3.1-12(a)(6)(A)			
F 0225 SS=F Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in			

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	progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	A. Based on record reviews and interview, the facility failed to ensure residents were free from potential abuse by not ensuring employees had a criminal background check completed before hiring for 8 of 8 employee records reviewed with a hire date of 2105. This deficiency had the potential to affect 53 of 53 residents in the facility. (Employee #, 65, #80, #82, #61, #83, #84, #85 and #86) B. Based on observations, record reviews and interview, the facility failed to ensure allegations of abuse/mistreatment were thoroughly investigated for 4 of 5 allegations reviewed. (The 4 allegations reviewed involved Resident #33, Resident #8, Resident #68, Resident #76 and Resident #61) Findings include: A.1. On 10/30/15 at 10:30 A.M., a review of the employee records was	F 0225	**F 225** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** 1.Employee#65, #80, #82, #61, #83, #84, #85, #86- complete background checks were obtainedwith no negative findings 2.1. Incident#19 involving Resident #33, CNA #8 & Resident #61- Resident #33 andResident #61 had no negative effects. 2. Incident #10 involving Resident #68& CNA #8, no further	12/04/2015

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	conducted. The following employees had an offender search completed from the Indiana Department of Correction: There was no documentation to indicate a criminal history check had been completed. *Employee #85, R.N. (Registered Nurse), date of hire - 10/5/15 *Employee #84, Social Service Director, date of hire - 6/22/15 *Employee #80, R.N., date of hire - 4/2/15 *Employee #65, LPN (Licensed Practical Nurse), date of hire - 10/8/15 *Employee #82, CNA (Certified Nursing Assistant), date of hire - 1/9/15 *Employee #86, CNA, date of hire - 10/15/15 *Employee #83, CNA, date of hire - 10/15/15 *Employee #61, Dietary, date of hire - 9/21/15 There was no documentation to indicate a criminal history check had been completed. On 10/30/15 at 2:45 P.M., an interview was conducted with the Administrator and Human Resource Manager (HR). HR indicated she has checked all employees since the facility became Aperion last year (2014) using the IN.gov		incidents have occurred. 3. Incident #14 involving Resident #7& Resident #76, Resident #7 no longer resides in this facility. 4. Incident #20 involving Resident #33& Resident #61, no further incidents have occurred. **1. How the facility identified other resident:** 1. All employees hired since August 2014 fileshave been audited and complete criminalbackground checks were obtained. 2.All ISDHIncident reports submitted in the last 30 days have been audited to ensureinvestigations are complete. **1. Measures put into place/systems changes:** 1. New employee files will be reviewed within 7days to ensure that criminal background checks were submitted and obtained. TheAdministrator or designee will be responsible for oversight of these audits. 2.Licensedpersonnel and members of the IDT were educated on the reporting andinvestigation guidelines for unusual occurrences. With each report of an unusual occurrence,a check off sheet will be initiated to ensure all required	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	website. She indicated this was the way she had been instructed to complete a criminal history check. The offender search form indicated the website used was from the Indiana Department of Correction. The search was an "Indiana Offender Database Search." On 10/30/15 at 3:35 P.M., the Administrator provided the Employment Policies, Procedure and Rules, no date, and indicated the policy was the one currently being used by the facility. The section for "REFERENCE AND BACKGROUND CHECKS" indicated "Criminal background checks of all employees will be performed pursuant to the requirements of state and / or federal law." B.1. On 11/1/2015 at 1:51 P.M., a form titled "Incident Number 19," dated 10/25/2015 at 5:54 P.M., indicated CNA #8 observed Resident #61's hand on Resident #33's groin while they were in the dining room. CNA #8 immediately separated the residents and place residents on 15 minute checks. Family members of the two residents were notified, as well as their physicians. The DON (Director of Nursing) and Administrator were also notified. New		elements of theinvestigation are present. TheAdministrator or designee will review each investigation prior to submission of5 day follow up report to ensure that the investigation was complete, includingresident and staff statements. **1. How the corrective actions will be monitored:** The results of these auditswill be reviewed in Quality Assurance Meeting monthly until 100% compliance isachieved for 3 consecutive months. **1. Date of compliance:** **12-4-15**	

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	155702	A. BUILDING 00 B. WING	11/04/2015

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	orders noted by physician and psychiatry to follow up with both residents, as well as social services. There was no other documentation of investigation available for review. B.2. On 11/1/2015 at 2:36 P.M., a form titled, "Incident Number 10," dated 9/20/2015 at 3:01 P.M., indicated CNA #8 told Resident #68 to shut up because she wanted to put the resident in bed. On 9/21/15 CNA #8 was removed from the facility, a head to toe assessment was completed. The resident's physician, responsible party, administrator and director of nursing were notified. The preventative measures added, on 9/21/2015, indicated Social services interviewed the cognitive residents, and statements were received from co-workers present during time of allegation and the care plan was reviewed and updated. A follow up of the incident, on 9/24/15, with CNA #10 indicated she was in the room with CNA #8 and had not heard CNA #8 telling the resident to shut up about going to bed. Another follow up, indicated Resident #68 indicated she was told to shut up when she was put in her wheelchair and said "ouch." She also stated that this incident also happened at another facility she was in. No other allegations were on file for			

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	CNA #8. The Social Service Director interviewed other alert and oriented residents and there were no other negative reports of care given by CNA #8. CNA #8 was placed back on the schedule and will complete education on Abuse and Neglect and Resident Rights before returning to the nursing unit. There was no documentation of an investigation to indicate other residents on the unit were interviewed. B.3. On 11/1/2015 at 2:56 P.M. a form titled, "Incident Number 14," indicated that on 10/14/2015 at 1:18 P.M., Resident #7 was observed by LPN #71 and CNA #72 making an obscene hand gesture to Resident #76. Resident #76 responded by stating "I'm going to kick the [expletive] out of you." Immediately both residents were separated and both residents were able to calm down. The DON, Administrator, and the residents' physician were notified. Families for both residents were notified. The Social Service Director was notified and spoke with both residents and encouraged both residents to avoid one another. Psychiatric services was notified of the occurrence, as well. Fifteen minute checks were initiated for safety. An order was obtained for evaluation and treatment at a geriatric neuro-psych			

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	hospital and Resident #7 voluntarily was sent today (10/20/15) to a local Neuro-Psychiatry Hospital for further evaluation and treatment. There was no further investigation to review. B.4. On 11/1/2015 at 4:06 P.M., a form titled, "Incident Number 20" indicated on 10/26/2015 at 1:55 P.M., Resident #61 was observed by CNA #73, with her hand in Resident #33's pants and touching his groin area. The two residents were immediately separated and assessed for injuries and none were noted. There were no signs/symptoms of distress observed. The family members of the two residents were notified and came to the building to sit with each resident. Physicians for both residents, the DON and Administrator were notified. The resident's were placed on 15 minute checks. Social Service was notified and psych services were notified. An order was obtained to send Resident #61 to behavioral unit for an evaluation and treatment. Follow up: Blank. No other interviews with residents or staff were documented. During an interview, on 10/30/2015 at 9:15 A.M., the Administrator indicated that if an abuse allegation is brought			

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	forth, the first thing would be to protect the residents involved. Then the staff member involved would be suspended until the investigation was completed. Once the investigation was completed the staff member would return to work or loose their job. She further indicated that the Executive Director, Director of Nursing and the Social Service Director would interview all the individuals who were involved in the allegation. On 11/1/2015 at 1:45 P.M., the DON provided a policy titled, "Abuse, Neglect and Misappropriation of Resident Property", undated, and indicated the policy was the one currently use by the facility. The policy indicated "...11. The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress...." During an interview, on 10/30/2015 at 10:00 A.M., the Social Service Director indicated that she had interviewed the residents involved in the incidents and had several follow up conversations with all the residents involved to see how they were perceiving the past incidences. The Social Service Director indicated that she did not document those visits. During an interview on 10/30/2015 at			

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	1:30 P.M., the Consultant DON #74 indicated that several administration changes have been made lately and with all the moving the files have been lost. 3.1-28 (b)(1)(A) 3.1-28(c) 3.1-28(d)			
F 0226 SS=F Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. A. Based on record reviews and interview, the facility failed to ensure residents were free from potential abuse by not implementing their policy to ensure the employees had a criminal background check completed before hiring for 8 of 8 employee records reviewed with a hire date of 2105. This deficiency had the potential to affect 53 of 53 residents in the facility. (Employee #, 65, #80, #82, #61, #83, #84, #85 and #86) B. Based on interview and record review, the facility failed to ensure their abuse policy and procedure was implemented	F 0226	**F 226** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:**	12/04/2015

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	regarding the investigation of an allegation of abuse/mistreatment for 4 of 5 abuse allegations reviewed. (The 4 allegations reviewed included Resident #33, Resident #8, Resident #68, Resident #76 and Resident #61) Findings include: A.1. On 10/30/15 at 10:30 A.M., a review of the employee records was conducted. The following employees had an offender search completed from the Indiana Department of Correction: There was no documentation to indicate a criminal history check had been completed. *Employee #85, R.N. (Registered Nurse), date of hire - 10/5/15 *Employee #84, Social Service Director, date of hire - 6/22/15 *Employee #80, R.N., date of hire - 4/2/15 *Employee #65, LPN (Licensed Practical Nurse), date of hire - 10/8/15 *Employee #82, CNA (Certified Nursing Assistant), date of hire - 1/9/15 *Employee #86, CNA, date of hire - 10/15/15 *Employee #83, CNA, date of hire - 10/15/15 *Employee #61, Dietary, date of hire - 9/21/15		1.Employee #65, #80, #82, #61, #83, #84, #85, #86- complete background checks were obtained with no negative findings 1.1. Incident #19 involving Resident #33, CNA #8 & Resident #61- Resident #33 and Resident #61 had no negative effects. 2. Incident #10 involving Resident #68 & CNA #8, nofurther incidents have occurred. 3. Incident #14 involving Resident #7 & Resident #76,Resident #7 no longer resides in this facility. 4. Incident #20 involving Resident #33 & Resident #61,no further incidents have occurred. **1. How the facility identified other resident:** 1. All employees hired since August 2014 files have been audited and complete criminal background checks were obtained. 2.All ISDH Incident reports submitted in the last 30 days have been audited to ensure investigations are complete. **1. Measures put into place/systems changes:** 1. New employee files will be reviewed within 7 days to ensure that criminal background checks were submitted and obtained. The Administrator or designee will be responsible for oversight of	

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	There was no documentation to indicate a criminal history check had been completed. On 10/30/15 at 2:45 P.M., an interview was conducted with the Administrator and Human Resource Manager (HR). HR indicated she has checked all employees since the facility became Aperion last year using the IN.gov website. She indicated this is the way she was instructed to complete a criminal history check. The offender search form indicated the website used was from the Indiana Department of Correction. The search was an "Indiana Offender Database Search." On 10/30/15 at 3:35 P.M., the Administrator provided the Employment Policies, Procedure and Rules, no date, and indicated the policy was the one currently being used by the facility. The section for "REFERENCE AND BACKGROUND CHECKS" indicated "Criminal background checks of all employees will be performed pursuant to the requirements of state and / or federal law." B.1. On 11/1/2015 at 1:51 P.M., a form		these audits. 1.Licensed personnel and members of the IDT were educated on the reporting and investigation guidelines for unusual occurrences. With each report of an unusual occurrence, a check offsheet will be initiated to ensure all required elements of the investigationare present. The Administrator ordesignee will review each investigation prior to submission of 5 day follow upreport to ensure that the investigation was complete, including resident andstaff statements. **1. How the corrective actions will be monitored:** Theresults of these audits will be reviewed in Quality Assurance Meeting monthlyuntil 100% compliance is achieved for 3 consecutive months. **1. Date of compliance: 12-4-15**	

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	titled "Incident Number 19", dated 10/25/2015 at 5:54 P.M., indicated CNA #8 observed Resident #61's hand on Resident #33's groin while they were in the dining room. CNA #8 immediately separated the residents and place residents on 15 minute checks. Family members of the two residents were notified, as well as their physicians. The DON and Administrator were also notified. New orders noted by physician and Psychiatry to follow up with both residents, as well as social services. There was no further documentation of investigation for review. B.2. On 11/1/2015 at 2:36 P.M. a form titled, "Incident Number 10" dated 9/20/2015 at 3:01 P.M., indicated CNA #8 told Resident #68 to shut up because she wanted to put the resident in bed. On 9/21/15 CNA #8 was removed from the facility, a head to toe assessment was completed. The resident's physician, responsible party, administrator and director of nursing were notified. The preventative measures added, on 9/21/2015, indicated Social services interviewed the cognitive residents, and statements were received from co-workers present during time of allegation and the care plan was reviewed and updated. A follow up of the incident			

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	on 9/24/15 with CNA #10 indicated she was in the room with CNA #8 and had not heard CNA #8 telling the resident to shut up about going to bed. Another follow up, indicated Resident #68 indicated she was told to shut up when she was put in her wheelchair and said "ouch". She also stated that this incident also happened at another facility she was in. No other allegations were on file for CNA #8. The Social Service Director interviewed other alert and oriented residents and there were no other negative reports of care given by CNA #8. CNA #8 was placed back on the schedule and will complete education on Abuse and Neglect and Resident Rights before returning to the nursing unit. There was no further documentation of investigation for review. B.3. On 11/1/2015 at 2:56 P.M. a form titled, "Incident Number 14," indicated on 10/14/2015 at 1:18 P.M., Resident #7 was observed by LPN #71 and CNA #72 making an obscene hand gesture to Resident #76. Resident #76 responded by stating "I'm going to kick the [expletive] out of you." Immediately both residents were separated and both residents were able to calm down. The DON (Director of Nursing), Administrator, and the residents'			

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	physician were notified. Families for both residents were notified. The Social Service Director was notified and spoke with both residents and encouraged both residents to avoid one another. Psychiatric services was notified of the occurrence, as well. Fifteen minute checks were initiated for safety. An order was obtained for evaluation and treatment at a geriatric neuro-psych hospital and Resident #7 voluntarily was sent today (10/20/15) to a local Neuro-Psychiatry Hospital for further evaluation and treatment. B.4. On 11/1/2015 at 4:06 P.M., a form titled, "Incident Number 20" indicated on 10/26/2015 at 1:55 P.M., Resident #61 was observed by CNA #73, with her hand in Resident #33's pants and touching his groin area. The two residents were immediately separated and assessed for injuries and none were noted. There were no signs/symptoms of distress observed. The family members of the two residents were notified and came to the building to sit with each resident. Physicians for both residents, the DON and Administrator were notified. The resident's were placed on 15 minute checks. Social Service was notified and psych services were notified. An order was obtained to send Resident #61 to behavioral unit for an evaluation and			

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	treatment. There was no follow up documentation and no resident interviews that resided on same unit that incident occurred. During an interview, on 10/30/2015 at 9:15 A.M., the Administrator indicated that if an abuse allegation is brought forth, the first thing would be to protect the residents involved. Then the staff member involved would be suspended until the investigation was completed. Once the investigation was completed the staff member would return to work or loose their job. She further indicated that the Executive Director, Director of Nursing and the Social Service Director would interview all the individuals who were involved in the allegation. On 11/1/2015 at 1:45 P.M., the DON provided a policy titled, "Abuse, Neglect and Misappropriation of Resident Property", undated, and indicated the policy was the one currently use by the facility. The policy indicated "... 11. The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress...." 3.1-28(a)			

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F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for 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. Based on observation, record review and interviews, the facility failed to ensure residents were served meals on proper tableware on 2 of 3 nursing units. In addition, the facility failed to ensure 1 of 35 residents observed for dressing needs was dressed in personal clothing. (Resident #76) Finally, the facility failed to ensure staff were talking with 2 of 2 residents who required feeding assistance in 1 of 2 dining rooms during one of 3 meal observations. (Resident #41 and 80) Findings include: 1. During the Kitchen Sanitation Tour, conducted on 10/26/15 at 10:15 A.M., the FSS (Food Service Supervisor) indicated the facility's dishwasher had been broken for a few weeks. The residents in the Main and West dining rooms were served using paper products and plastic utensils. During the observation of the meal	F 0241	**F 241** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** 1.Thedishwasher was installed and fully operational on 11/4/15. All residents have been served meals onregular tableware thereafter. 2.Resident#76- appropriate clothing has been obtained. 3.Resident#41 & Resident #80 have had no negative outcomes observed from limitedconversation during meal service. CNA#53 was educated	12/04/2015

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	service, conducted on 10/26/15 at 12:00 P.M., several residents asked when the dishwasher was going to be fixed and indicated they would be glad to have "real" table service and silverware. On 11/02/15, the Maintenance Director provided documentation indicating the dishwasher had been broken since the weekend of October 3 or 4th. During the breakfast meal observation, conducted on 11/30/15 at 7:00 A.M., Resident #27 complained of the length of time the residents had been served their meals on paper products. He indicated the day before, as nursing staff were delivering his meal to him at the dining room table, the paper plate bent and his food dumped all over the table and floor and he had to wait for more food to be made for him. 2. The clinical record for Resident #76 was reviewed on 11/2/2015 at 3:42 P.M. Resident #76 was admitted to the facility, on 07/02/15, with diagnoses, including but not limited to: urinary tract infection, dementia without behavioral disturbance, hypertension, heart failure, gastro-esophageal reflux, urine retention and osteoarthritis. The resident's BIMS (Brief Interview for		on communication during meal service. **1. How the facility identified other resident:** All resident's closets have been audited to ensure appropriate clothingis available. All resident's dependent on staff during mealshave the potential to be affected. **1. Measures put into place/systems changes:** Nursing staff were educated oncompleting a social service referral form for resident clothing needs if nopersonal clothing is available, as well as dressing residents in appropriate,clean clothing changed daily. Nursingstaff were re-educated on appropriate communication with a resident during meal service. **1. How the corrective actions will be monitored:** Meal service will be observed to ensureappropriate tableware is provided and staff is communicating with residentsduring assistance at least 3x/ week x30 days at varied meals and locations,then weekly thereafter at varied meals and locations until 100% compliance isachieved x3 consecutive months.. Dignity rounds will becompleted at least 3x/week x30 days at	

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	Mental Status) score on the Admission MDS (Minimum Data Set) assessment, completed on 07/12/15, was a score of 4, which indicated she was severely cognitively impaired. A nursing care plan meeting progress note, dated 10/14/15, indicated there were no nursing concerns. On 10/27/15 at 2:41 P.M., Resident #76 was observed dressed in a hospital gown with a zip up sweater over top of the gown. Interview with Resident #76's roommate and observation of Resident #76's closet indicated one skirt hanging in the closet and no other clothes. Resident #76's roommate indicated the resident had no clothes except for a skirt she had given the resident. On 10/28/15 at 9:30 A.M., Resident #76 was observed in the dining room, dressed in a pink flowered shirt and purple pants with the same cream/white zip up cardigan sweater on that she wore on 10/27/15. The zip up cardigan sweater had a pink stain on the shoulder. On 10/29/15 at 9:15 A.M., Resident #76 was observed in the dining room in her wheelchair at a dining room table with the same outfit on as she had worn the day before.		varied times, then weekly thereafteruntil 100% compliance is achieved x3 consecutive months to ensure residents aredressed appropriately. An audit will be completed of5 resident closets per week to ensure adequate and appropriate clothing isavailable x90 days, then 1 resident per week thereafter until 100% complianceis achieved x3 consecutive months. The Administrator or designeewill be responsible for oversight of these audits. The results of these auditswill be reviewed in Quality Assurance meeting monthly until 100% compliance isachieved x3 consecutive months. **1. Date of compliance: 12-4-15**	

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	155702	A. BUILDING 00 B. WING	11/04/2015

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	On 10/29/15 at 2:45 P.M., Resident #76 was observed in her room in her wheelchair in a hospital gown with the same white/cream zip up sweater which had a pink stain on it. The only clothes in her closet was a brown skirt on a hanger. On 10/30/2015 at 11:29 A.M., Resident #76 was observed in wheelchair dressed in gown covered with the same cream colored zip up sweater with a pink stain on it. CNA (Certified Nursing Assistant) #50 indicated the resident did not have any clothes to wear. She indicated she had filled out a note for the Social Service Director regarding the lack of clothes for Resident #76. On 11/02/2015 at 2:35 P.M., Resident #76 was observed in her room in her wheelchair, dressed in a brown skirt from her roommate and a purple night gown covered with the same cream zip up sweater with a pink stain on it. The only clothes noted in her closet was a purple duster bathrobe. During an interview, on 11/02/15 at 3:30 P.M., the SSD indicated she had never been notified of the need for clothing for Resident #76. She indicated staff could notify her verbally or in writing. She indicated there was donated clothing and			

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	she would go get the resident some clothing. During an interview, on 11/02/2015 at 3:40 P.M., CNA #51 indicated she had never notified the SSD regarding the need for clothing for Resident #76. She indicated she was aware the resident wore gowns a lot and always wore a cream colored zip up sweater. On 11/04/15 at 2:15 P.M., Resident #76 was again observed seated in her wheelchair in the nursing unit lounge dressed in a hospital gown and the same cream colored zip up cardigan. CNA #52 indicated Resident #76 still had no clothes so she had to wear the hospital gown. During an interview, on 11/04/15 at 3:00 P.M., the SSD indicated she could not find the correct size for Resident #76 in the box of donated clothing but she was hoping to go to a thrift shop over the weekend and find her some clothes. She indicated she had also telephoned the resident's daughters who indicated they would bring in some clothing for the resident. 3. On 10/30/15 at 7:00 A.M., during an observation of the breakfast meal service on the West unit, CNA #53 was noted to			

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	provide feeding assistance to Resident #41 and Resident #80. Other than telling Resident #41 "You're hungry" she did not speak to the resident the entire time she was feeding the resident. She only asked Resident #80 twice if he was ready for a bite and once if he was ready for a drink when she was feeding him. 3.1-3(t)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observations, interview and record reviews, the facility failed to ensure residents preferences/choices were accommodated for 3 of 5 residents reviewed for choices. This deficiency related to smoking, bathing and time to get up in the morning choices. (Resident #11, Resident #68 and Resident #18) Findings include:	F 0242	**F 242** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or*	12/04/2015

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	1. During the entrance conference, on 10/26/15 at 10:40 A.M., the Administrator indicated the facility was a non-smoking campus. On 10/26/15 at 10:45 A.M., the Administrator provided a policy titled "Smoking Policy", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Purpose: To ensure a safe and healthy environment for residents, employees and visitors in Accordance with with state law...Policy: Resident tobacco Use is prohibited throughout the campus... Standards: 1. Signs shall be posted at primary entrances in order to inform individuals of the no smoking status of the campus. 2. Prior to the time of admission, resident/sponsors will be informed of the no smoking policy. 4. Aperion Care facilities may not allow the Resident use of electronic cigarettes on the facility grounds. 5. Oral tobacco products are prohibited on the Aperion Care facility campus...." The bottom of the policy had an area where a family Signature and date could be completed. The Administrator also provided a typed statement, dated 10/26/15, which indicated "...We currently have no smoking residents in the facility...." During the initial tour, on 10/26/15 at 10:50 A.M., there was no signage observed, at main entrance, indicating the		*executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** 1.Resident#11 the MDS has been updated to indicate tobacco use, and a copy of the smokingpolicy has been presented & signed. Orders obtained for a transdermal nicotine patch per his request. 2.Resident#68 resident choice assessment completed and 1st choice of showerwas indicated and preference for getting up in the morning were placed on theresident care plan and kardex. The shower schedule has been updated. 3.Resident#18 resident choice assessment was completed and 1st choice ofshower was place placed on the residents care plan and kardex for 2 times aweek. **1. How the facility identified other resident:** 1. 100% audit was completed on all admissionfiles. Those admissions without a signedcopy of the smoking policy will be provided one and a signed copy will bemaintained in the resident admission packet. 2. Resident choice preference assessment wascompleted on all resident in the facility and care plans and kardexs have beenupdated.	

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	facility was non-smoking. On 10/26/15 at 2:24 P.M., the Administrator and the Director of Nursing were observed outside, standing to the right of the front entrance, smoking. The Administrator could not explain why they were smoking outside when they disclosed earlier the facility was a non-smoking facility. During an interview, on 10/26/15 at 2:30 P.M., the Administrator indicated the staff handbook allowed staff to smoke outside designated areas. The Administrator indicated when she started at the facility she was informed the building was non-smoking and had told Resident #11 he could no longer smoke. The undated handbook indicated "...Smoking: In keeping with the facilities intent to provide a safe and healthy work environment, smoking generally is prohibited inside the Facility except in designated areas...." During an interview, on 10/26/15 at 3:30 P.M., Resident #11 indicated he was a smoker but was told by the new administrator, he could no longer smoke or use his electronic cigarettes in the facility or outside of the facility. The resident further indicated he used to go		**1. Measures put into place/systems changes:** 1. The Admissions Director was educated on acheck off list to use when putting admission packets together. A copy of the check off sheet will beplaced in the front of the admission file and a copy will be retained by theadmission director. 2. The Activity Staff and Nursing Management wereeducated on Resident Choice/Preference assessment and schedule for review aswell as update of care plan and kardex. 3.Nursingstaff was re-educated on resident choice/preference on showers/bathing andbedtime/rising times to be found on Kardex. **1. How the corrective actions will be monitored:** The Administrator or designeewill audit all new admission paperwork the next business day after a newadmission to ensure a copy of the smoking policy was provided. The Director of Nursing ordesignee will audit 10 resident bathing records per week on varied units andshifts to ensure bathing is provided according to preference and care plan x30days, then 5 bathing records per week on varied units and shifts until 100%compliance is	

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	outside on his motorized wheelchair and smoke, but had been prohibited to, since the last administrator left. He further indicated the last administrator, at the facility, had bought his electronic cigarettes on line for him. The resident indicated he no longer had any cigarettes of any kind, as they were taken away from him and stored somewhere. The resident indicated he had never signed a form indicating he was informed of the non-smoking policy, he was only told verbally, approximately a month ago. The resident indicated he had seen staff members outside smoking and doesn't understand why they can smoke and he can not. He further indicated the administrator nor his physician had offered him a nicotine alternative, such as a nicotine patch or gum. On 10/28/15 at 2:30 P.M., the Admission Coordinator provided a Move-In Agreement for Resident #11, dated 10/29/14. The Move-In Agreement did not indicate the facility was a non-smoking facility. The Admission Coordinator also provide a new resident admission packet and it did not contain information regarding the facility being a non-smoking facility. On 10/30/15 at 9:30 A.M., a review of the clinical record for Resident#11 was		achieved x3 consecutive months. The Director of Nursing ordesignee will interview 5 residents per week until 100% compliance is achievedx3 consecutive months to ensure preferences for bedtime/rising time and bathingare honored. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1.Dateof compliance: 12-4-15**	

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	conducted. The record indicated the resident was admitted 10/29/14. The resident's diagnoses included, but were not limited to: chronic airway obstruction disease, diabetes, hypertrophy prostate, retention of urine, and urinary obstruction. The Quarterly Minimum Data Assessments, dated 7/17/15 & 8/27/15, did not assess Resident #11's current tobacco use. The resident's cognition score indicated resident had no memory/cognition problems. A Social Service Note, dated 9/9/15, indicated the Social Service Director (SSD) and the Administrator went to the resident's room and asked for any smoking materials. The resident gave them his electronic cigarette and vapor tank. Another Social Service Note, dated 9/28/15, indicated the nursing staff had told the SSD the resident had another electronic cigarette and accessories. The resident was re-educated regarding the non-smoking policy and resident handed over to the SSD two vapor smoking devices. The material was stored in the SSD's office. During an interview, on 11/4/15 at 9:20 A.M., the Social Service Director indicated the previous administrator had			

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	allowed residents to smoke outside the facility, however the current administrator had determined the facility was a non-smoking facility and the resident's were told they could no longer smoke outside the facility. 2. During an interview on 10/27/15 at 1:41 P.M., Resident #68 indicated she preferred to receive a bath, but was told by a staff member the tub was broken (door leaks). The resident further indicated she was woke up every morning, gotten dressed and placed in her wheelchair before she preferred to be. The resident indicated her preference would be to stay in bed unit at least 7:00 A.M. On 10/29/15 at 7:00 A.M., Resident #68 was observed sitting in her wheelchair, in the hallway. On 10/29/15 at 3:06 P.M., a review of the clinical record for Resident #68 was conducted. The record indicated the resident was admitted on 8/20/15. The resident's diagnoses included but were not limited to: cerebral infarction, diabetic type 2, dysphagia, gastro-esophageal reflux, hemiplegia/hemiparessis of left side, and visual loss both eyes.			

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	The Admission Minimum Data Set Assessment, dated 8/30/15, indicated it was important for her to be able to choose between a tub bath, shower bed bath or sponge bath. An Activities Interest Survey, dated 8/20/15 indicated the resident prefers to be awaken between 7:00 A.M. and 8:00 A.M. Her 1st choice for bathing preference was a shower and second choice was a bath. A shower schedule indicated the resident was to be assisted with bathing on the day shift on Wednesdays and Sundays. The Activities of Daily Living care plan did not indicate a bathing preference or a time when she would like to start her day. An ADL (Activities of Daily Living) report, dated 10/29/15, indicated the following: On 9/30/15 at 1:44 P.M., the resident received a shower. On 10/17/15 at 7:29 P.M., the resident received a bed bath. On 10/21/15 at 9:59 P.M., the resident refused to be bathed. On 10/23/15 at 11:45 A.M., the resident received a shower. On 10/24/15 at 4:09 P.M., the resident received a bed bath.			

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	During an interview, on 10/29/15 at 3:25 P.M., the Activity Director indicated the tub in the facility was functioning. The Activity Director indicated the tub was functioning. During an interview, on 10/30/15 at 9:44 A.M., RN (Registered Nurse) #1 indicated the resident was unable to propel herself in her wheelchair. The resident was also not able to get herself out of bed on her own. During an interview, on 10/30/15 at 10:20 A.M., Resident #68 indicated she had never received a bed bath and had never refused a shower. The resident further indicated CNA (Certified Nursing Assistant) #5 and other aides (couldn't recall their names) had told her the bath tub was broken. The resident further indicated two weeks ago her shower day was changed 4 times and the Unit Manager had told the resident she was on the night shift shower schedule currently. The resident indicated she believed she was currently on the night shift to get her shower. However, she had not received a shower this week and complained her hair was dirty. The resident indicated the aides tell her they don't have time. The resident's hair was observed to be oily.			

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	During an interview, on 11/2/15 at 830 A.M., CNA #7 indicated the shower list for the residents was in the nursing station. She referred to the bathing sheet and indicated Resident #68 should have received a shower yesterday. During an interview, on 11/2/15 at 8:40 A.M., the Director of Nursing indicated the Nurse Aide bathing sheet recorded the resident as receiving a bed bath on 10/31/15 (Saturday). During an interview, on 11/2/15 at 8:45 A.M., the resident indicated she did not receive a bed bath nor a shower yesterday or Saturday. Resident 68's hair was observed oily. During an interview, on 11/2/15 at 4:00 P.M., CNA #8 indicated she had given Resident #68 a bed bath on Saturday evening. She indicated she had provided peri care and washed the resident's face and hands. CNA #8 further indicated she had not washed the resident's hair and indicated she had not given the resident a shower because she didn't have time to complete a shower for the resident. She indicated she was aware the resident preferred a shower and her bathing days were Sunday and Wednesday. 3. During an interview, on 10/26/2015 at 2:47 P.M., Resident #18 indicated that			

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	she had requested two showers per week and that many times she did not receive those showers. On 10/29/2015 at 3:00 P.M., a form titled "ACTIVITIES INTEREST SURVEY" indicated that the Resident preferred showers. During an interview, on 11/02/2015 at 11:16 A.M., employee #5 indicated that there are many times when the nursing staff fail to assist residents with obtaining their showers in a timely manner. Resident #18's care plans indicated she preferred showers twice a week. Resident #18's ADL (Activities of Daily Living) report indicated the resident was to receive showers twice a week. On 11/02/2015 at 12:17 P.M., a record review of the facilities shower schedule indicated that Resident #18 was scheduled to have a shower every Wednesday and Sunday evening. Bathing records for Resident #18 documented the following: 10/3/15, Saturday, Bed Bath 10/7/15, Wednesday, Shower 10/17/15, Saturday, Bed Bath 10/24/15, Saturday, Non Applicable			

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	10/28/15, Wednesday, Non Applicable 3.1-3(u)(1) 3.1-3(u)(3)			
F 0250 SS=E Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interviews, the facility failed to ensure a behavior management program was implemented and monitored for 5 of 8 residents reviewed for psychoactive medication use. (Resident #20, #4, #39, #47 and #90) Findings include: 1. The clinical record for Resident #39 was reviewed on 11/02/2015 at 11:16 A.M. Resident #39 was admitted to the facility on 09/08/15 with diagnoses, including but not limited to: malformation of coronary vessels, diabetes mellitus, anxiety disorder, chronic obstructive pulmonary disorder, hyperlipidemia, chronic kidney disease stage 3, morbid obesity, heart failure, muscle wasting, diarrhea and difficulty	F 0250	**F250** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** 1.Resident#39 care plans and kardex updated with interventions and behaviors to bemonitored. 2.Resident#47 care plans and kardex updated with interventions and behaviors to bemonitored. 3.Resident#90 care plans and kardex updated with interventions	12/04/2015

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	walking. The current physician's orders for medication included the following psychoactive medications: Xanax (an antianxiety medication) .25 mg (milligrams) twice a day for anxiety, ordered on 10/19/15; Sertraline (an antidepressant medication) 150 mg once a day for anxiety state; Abilify 5 mg (an antipsychotic mediation) once a day for depression; Trazodone (an antidepressant medication) 150 mg at bedtime for depression; Valproic Acid 250 mg (an antiseizure medication often utilized for mood management) for depression. There were no care plans for Resident #39 regarding his behaviors or psychoactive medication use. During an interview on 11/2/15 at 2:20 P.M., LPN (Licensed Practical Nurse) #58 indicated the resident did not have any behaviors that they (nursing staff) track. When queried as to why an antianxiety medication was initiated on 10/19/15 she indicated she thought that was "weird" as the resident did not ever seem anxious to her. She indicated the resident preferred to stay in his room but he was talkative and liked to tease when		and behaviors to bemonitored. 4.Resident#4 care plans and kardex updated withinterventions and behaviors to be monitored. 5.Resident#20 care plans and kardex updated with interventions and behaviors to bemonitored. **1. How the facility identified other resident:** A review of care plans andkardex for all resident's receiving psychoactive medications for behaviors willbe completed. **1. Measures put into place/systems changes:** Nursing staff were educated onthe Behavior Management Program Binders, use of Kardex to indicate residentspecific behaviors and interventions and monitoring/documentation of behaviors. **1. How the corrective actions will be monitored:** The Social Service Director ordesignee will review 3 residents receiving psychoactive medications per week toensure behavior management program is in place, behavior documentation isreviewed and care plans/ Kardex are updated. The Social Service Directorand/or Director of Nursing will review all new psychoactive medication ordersduring clinical meeting and ensure a behavior management program andcommunication is in place. The results of these auditswill be	

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	staff entered his room. During an interview on 11/02/15 at 2:23 P.M., LPN #65 indicated the resident occasionally requested breathing treatments but did not display any signs and symptoms of anxiety or depression. She indicated she thought the resident preferred to stay in his room and sleep. During an interview, on 11/02/2015 at 3:13 P.M. the Social Service Director (SSD) indicated she was not sure why the resident was started on Xanax. She indicated he exhibited some depression but not anxiety. The SSD was also not aware of any specific behavior tracking for Resident #39. No documentation was provided to support the initiation of the Xanax for Resident #39. There were no care plans for Resident #39 regarding his behaviors or psychoactive medication use. During an interview on 11/02/15 at 3:07 P.M., the Social Services Director indicated there was no specific behavior tracking completed for Resident #39. She brought copies of the Kiosk (electronic chart) tracking for an unspecific behavior for Resident #39 and either "not applicable" or "none of the above observed" was charted for every shift on every day. It was unclear when charting "none of the		reviewed in Quality Assurance meeting monthly until 100% compliance isachieved x3 consecutive months. **1. Date of compliance:12-4-15**	

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	above observe"' to what the staff were charting when no targeted medical symptom or behavior had been identified and there were no behavioral care plans for Resident #39. The transfer orders from a previous long term care facility were reviewed on 11/02/15 at 3:15 P.M. with the SSD and the orders indicated the resident was receiving the Abilify due to severe recurrent major depression refractory, the Valproic Acid was given for headaches, the Zoloft was given for depression, and the Trazadone was given for Insomnia. The SSD indicated she was not aware of the previous diagnoses for Resident #39. She indicated the facility psychiatric nurse practitioner had assessed Resident #39 and she had ordered the Xanax. It was unclear if the nurse practitioner was aware of the previous medical symptoms for which the resident's current psychoactive medications were given. Resident #39 was observed, on 11/02/15 at 2:30 P.M., lying in his room, in his bed awake. The resident was alert, talked and smiled during the conversation. 2. The clinical record for Resident #47 was reviewed on 11/02/2015 at 9:23 A.M. Resident #47 was admitted to the facility, on 05/02/14, with diagnoses,			

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	including but not limited to: status post acute myocardial infarction, muscle weakness, difficulty in walking, diabetes mellitus, hypertension, hypothyroidism, vascular dementia with behavioral disturbances, adjustment disorder with depressed mood, psychosis, and muscle washing and atrophy. The current physician's orders for medications included the following psychoactive medications: Risperdal (an antipsychotic medication) 0.25 mg twice a day related to a delusional disorder; Celexa 20 mg once a day for depressive disorder. The resident had care plan related to her vascular dementia with delusions. The care plan indicated her delusions were often regarding people taking her things, that she was to leave the facility, or that Jesus told her she was dying. The Kardex for Resident #47, with information regarding behavior tracking for the CNA (Certified Nursing Assistant) staff indicated the resident was to be monitored for pacing, wandering, inappropriate response to verbal communication, violence/aggression towards others/staff and disrobing.			

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	During an interview, on 11/02/15 at 12:30 P.M., the SSD indicated the Kardex information with targeted behaviors was incorrect for Resident #47. During an interview, on 11/02/15 at 2:30 P.M., CNA #62 indicated she was not aware of any behaviors being monitored for Resident #47. During an interview, on 11/02/15 at 2:32 P.M., LPN (Licensed Practical Nurse) #59 indicated the resident will talk to someone who is not there all the time but she does not consider that a behavior but rather a part of her dementia. LPN #59 indicated the resident used to be on the dementia unit and so she exhibits signs and symptoms of dementia. 3. The clinical record for Resident #90 was reviewed on 10/28/15 at 2:00 P.M. Resident #90 was admitted to the facility, on 10/17/15, with diagnoses, including but not limited to: Chronic Obstructive Pulmonary Disease. The current physician's orders for medication for Resident #90 included the medication, Buspairone 10 mg (an antianxiety medication) twice a day per the gastrostomy tube and Cymbalta (an antidepressant) 60 mg one a day per the gastrostomy tube. The orders indicated			

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	the Buspairone was for depression and the Cymbalta was for pain. There were no care plans regarding the medication use and no specific tracking of anxiety for Resident #90. During an interview, on 10/28/15 at 3:00 P.M., CNA #64 indicated there was no specific information for Resident #90 in the Kardex. CNA #64 indicated she was also not aware of any behavior issues or monitoring she was to perform for the resident. During an interview, on 10/29/15 at 9:41 A.M., CNA #55 indicated there were no specific behavior or mood monitoring indicated for Resident #90. She attempted to look for information on the Kardex but there was no information available for Resident #90. During an interview, conducted on 11/02/15 at 9:10 A.M., LPN #65 indicated she had only worked at the facility for two weeks and was not sure what behaviors were to be monitored for Resident #90. LPN #65 attempted to look at the medical diagnoses, which only listed Congestive Obstructive Pulmonary Disease. She looked at the current medication orders and noted the antianxiety medication but she could not			

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	locate a care plan with instructions on behavior monitoring. During an interview, on 10/28/2015 at 3:07 P.M., LPN #54 indicated there was only one care plan regarding activities for Resident #90 and nothing (care instructions or interventions) in the Kardex (electronic system for CNAs). During an interview, on 11/02/15 at 10:40 A.M., LPN #60 indicated the nursing administrative team were supposed to initiate the care plans. She indicated interventions on the care plans would have then transferred onto the Kardex screen utilized by CNAs when providing care for residents. She indicated the facility no longer utilized paper assignment sheets with care instructions for CNAs they were just supposed to look at the Kardex for those instructions. She indicated administrative nursing staff were having to work on the floor due to staffing issues and shortages and care plans had just not gotten done. 4. On 10/30/15 at 1:30 P.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/18/15. The resident's diagnoses included, but were not limited to: aftercare following joint replacement surgery, diabetes type 2,			

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	phonologica disorder, dysphagia, cellulitis, adjustment disorder with depressed mood, edema, cardiac murmur and edema. The Medication Administration Record (MAR), dated 10/1/15 through 10/31/15, indicated the resident was being administered the following medications: Ambien (hypnotic) 5 milligrams (mg) at bedtime for insomnia, melatonin (a natural supplement given to induce sleep) 3 mg at bedtime for insomnia and nortriptyline (an antidepressant) 25 mg at bedtime for anxiety disorder. The Admission MDS (Minimum Data Set) assessment, dated 9/25/15, indicated the resident had no behaviors and had no symptoms of feeling depressed or trouble falling or staying asleep. Forms titled "Monitor - Behavior Symptoms" dated 10-1 through 10/30/15 indicated the resident had no behaviors. 5. On 10/30/15 at 9:19 A.M., record review for Resident #20 was conducted. Resident #20 was admitted to the facility, on 7/15/15, with diagnoses included, but were not limited to, Parkinson's disease, restless leg syndrome, Alzheimer's disease, insomnia and delirium.			

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	The Admission MDS (Minimum Data Set) assessment, completed on 7/25/15, indicated Resident #20 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 3. The MDS behaviors assessment indicated the resident was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. The Nursing Admission/Re-Admit Observation Assessment, dated 7/15/15, indicated no Behavior/Mood. A Behavior Log, for July 2015, indicated the following: *On 7/22/15 at 3:50 A.M., rejection of care during toileting. *On 7/26/15 at 1:59 P.M., wandering. *On 7/30/15 at 11:53 P.M. resident pushing during toileting. A nursing progress note, dated 7/21/15, indicated "...resident continues to attempt to stand and ambulate without assistance throughout shift...." A physician order, dated 7/21/15, indicated Quetiapine (an antipsychotic) 50 mg (milligram) by mouth two times a day related to delirium. A nursing progress note, dated 7/22/15 at			

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	9:17 A.M., indicated "...residents son tells writer that resident has been on antibiotics for prevention and treatment of frequent UTI's [urinary tract infection] and recommends the facility call the [physician name] to get prescriptions of rotating antibiotics...Son says resident gets more active when she gets a UTI and believes resident has a UTI now...." A nursing progress note, dated 7/22/15 at 11:55 A.M., indicated "...writer called [physician name] and reported sons concern of increased restless and increased urination and sons concern of UTI present. [physician name] ordered UA c&s [urinalysis with a culture and sensitivity]. Urine collected...[physician name] ordered if positive results of UA that resident is to increase dosage of Macrobid [antibiotic given for infection] to 100 mg bid [twice daily] for 5 days then return to normal dose of 100 mg every day...." A nursing progress note, dated 7/29/15 at 9:51 A.M., indicated "...resident has been restless this shift, attempting to stand and ambulate without staff assistance multiple times...." A nursing progress note, dated 7/30/15 at 11:47 P.M., indicated "...resident being very combative and would not accept			

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	help when transferring to the restroom or to the bed. Will continue to monitor...." A nursing progress note, dated 7/31/15, indicated "...behavior noted for frequently attempting to stand and ambulate without staff assistance...." A Behavior Log, for August 2015, indicated the following: *On 8/9/15 at 1:59 P.M., wandering. *On 8/12/15 at 1:14 P.M., wandering. *On 8/13/15 at 1:46 P.M., resident kicking/hitting. *On 8/18/15 at 12:49 A.M., rejection of care during toileting. *On 8/19/15 at 1:14 A.M., rejection of care during toileting. *On 8/19/15 at 10:12 A.M., wandering. *On 8/21/15 at 10:24 A.M., resident kicking/hitting during toileting. *On 8/21/15 at 9:59 P.M., resident yelling/screaming. *On 8/23/15 at 10:25 A.M., resident kicking/hitting during personal hygiene. *On 8/24/15 at 4:50 A.M., rejection of care during toileting. *On 8/30/15 at 3:41 P.M., resident kicking/hitting. *On 8/31/15 at 12:34 A.M., rejection of care during toileting. A Behavior Log, for September 2015, indicated the following:			

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	*On 9/4/15 at 9:24 P.M., threatening behavior. *On 9/30/15 at 10:24 A.M., resident kicking/hitting during toileting. A behavior Log, for October 2015, indicated the following: *On 10/9/15 at 11:03 A.M., resident biting during toileting. *On 10/18/15 at 10:33 A.M., kicking/hitting during personal hygiene *On 10/29/15 at 3:52 A.M., pinching/scratching/spitting during toileting A nursing progress note, dated 10/10/15, indicated "...resident is pleasant and sitting in lounge with others...Whenever resident is restless, she usually needs to be toileted...." The Quarterly MDS assessment, completed on 10/2515, indicated Resident #20 was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. A Note to Attending Physician/Prescriber, dated 10/29/15, indicated this resident is receiving Seroquel (an antipsychotic) 50 mg every morning and 50 mg every evening for Delirium due to physiological condition.			

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	Please consider dose reduction to Seroquel 25 mg twice a day. A physician order, dated 10/29/15 at 6:11 P.M., indicated Seroquel 25 mg by mouth two times a day related to delirium. On 10/29/15 at 9:28 A.M., Resident #20 was seated in a chair in the activity room on the dementia unit attending an activity, she was calm no behaviors observed. At 10:57 A.M., the resident was ambulated with the assist of 1 staff member to the television lounge, the resident was not resistant or combative, no delusional behaviors observed. At 11:40 A.M., the resident's son came into visit her and ambulated her to the dining room, she was quiet and calm. At 2:39 P.M., the resident was seated in a chair in the lounge with other residents eating a cupcake. No behaviors observed. During an interview, on 10/30/15 at 9:01 A.M., LPN #13 indicated Resident #20 gets agitated at times when the staff try to provide care. She indicated the resident frequently gets up out of her chair unassisted but redirection usually helps. She further indicated the resident has never had delusions. On 10/30/15 at 9:15 A.M., Resident #20			

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	was awake and alert sitting in a chair in the activity room. At 10:45 A.M., a CNA was ambulating the resident in the hallway, the resident became resistant like she was trying to sit down in the hallway. At that time, her son came to visit and assisted the resident into her room. At 1:30 P.M., the resident was resting quietly in her bed. At 2:45 P.M., the resident's bed alarm was alarming, a CNA entered the room to find the resident standing in the middle of the room unattended. The CNA assisted the resident into the lounge where she was resting quietly in a chair. On 10/30/15 at 9:37 A.M., review of a care plan, initiated on 7/21/15, indicated "...focus: (resident name) uses antipsychotic/antidepressant medications r/t (related to) Alzheimer's disease and depression...." The interventions included but were not limited to "...Administer medications as ordered. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Monitor for adverse effects every shift, notify MD as needed...." There was no other care plan related to target behaviors or monitoring of behaviors for Resident #20. During an interview, on 11/2/15 at 8:57 A.M., the Social Service Director			

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	indicated Resident #20 does not have any verbal aggression, she has had some recent physical aggression and some restlessness but she does not consider that a behavior. She further indicated the nursing staff kept repeatedly charting the resident is having a behaviors when she got up out of the chair unattended. The Social Service Director indicated the resident does not have any delusions and no behavior care plans were developed because she does not exhibit anything that she would consider a behavior. 3.1-34(a)			
F 0257 SS=D Bldg. 00	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interview, the facility failed to ensure a room temperature was within acceptable parameters. This had the potential to affect 1 of 20 residents residing on the South hallway. (Resident #68) Finding includes: During an interview, on 10/27/15 at 1:43 P.M., Resident #68 indicated her room	F 0257	**F 257** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of*	12/04/2015

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	was too warm. On 11/2/15 from 10:45 A.M. to 11:45 A.M., an environmental tour was conducted with the Maintenance Director and the Housekeeping Supervisor, during which the following was observed: South hallway: At 11:08 A.M., a fan was observed running at Resident #68's bedside. The Maintenance Director checked the air temperature with his thermometer and indicated the temperature was 82 degrees Fahrenheit. During an interview, on 11/2/15 at 11:09 A.M., the Maintenance Director indicated it has been hard to regulate the heat in the building due to the fluctuation of the temperatures outside and also due to the type of boiler heat the facility uses. He further indicated the temperature of the room should be between 71-81 degrees Fahrenheit. 3.1-19(h)		*correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Immediate monitoring and adjustment ofHVAC systems and temperature was brought back within acceptable parameters. **2. How the facility identified other residentspotentially affected:** All residents have the potential to beaffected. **3.Measuresput into place/systems changes:** Preventative maintenance willbe completed quarterly on the HVAC system. Staff will be in-serviced onreporting resident complaints about temperature within rooms or common areas tothe Administrator or Maintenance department for follow up. **1. How the corrective actions will be monitored:** Maintenance will take ambient temperatures invarious resident rooms and common areas throughout the facility at varied timesat least 5x/ week x30 days, then weekly thereafter until 100% compliance isachieved x3 consecutive months. TheAdministrator is responsible for oversight of these audits.	

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	155702	A. BUILDING 00 B. WING	11/04/2015

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			Theresults of these audits will be reviewed in Quality Assurance Meeting monthlyuntil 100% compliance is achieved x3 consecutive months. **1.Dateof Compliance: 12-4-15**	
F 0273 SS=D Bldg. 00	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no 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 for therapeutic leave.) Based on record review and interview, the facility failed to ensure the admission MDS (Minimum Data Set) assessments were completed within 14 days of admission for 2 of 21 residents reviewed. (Resident #89 and #90) Findings include: 1. The clinical record for Resident #90 was reviewed on 10/28/15 at 1:45 P.M. Resident #90 was admitted to the facility on 10/17/15 with diagnoses, including but not limited to Chronic Obstructive Pulmonary Disease. The Admission MDS assessment	F 0273	**F 273** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident#90, the MDS Assessment has been completed.	12/04/2015

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	indicated it should have been completed on 10/24/15, but it was incomplete and still in progress. During an interview, on 10/30/2015 at 2:31 P.M., the MDS coordinator, RN (Registered Nurse) #54 indicated she was aware of the late, incomplete MDS assessments, including the assessment for Resident #90. In addition, until very recently, she had been asked to help out providing nursing care on the floor due to staffing issues at the facility and the neighboring assisted living facility. She indicated she had asked the corporate consultant for help to assist her with an action plan to correct the issues she was experiencing. On 11/04/15 at 11:00 A.M., the admission MDS for Resident #90 was still incomplete and "in progress." 2. On 10/29/15 at 11:12 A.M., record review indicated, Resident #89 was admitted to the facility on 10/2/15, with diagnoses included, but were not limited to, "...sleep apnea, bronchitis, hyperlipidemia and dementia with behavioral disturbances...." The Admission MDS (Minimum Data Set) assessment, dated 10/11/15, indicated the assessment areas for health		Resident#89, the MDS Assessment has been completed. **2. How the facility identified other residentspotentially affected:** MDS schedule has been reviewed and allpast due MDS have been completed. **3.Measuresput into place/systems changes:** The MDS Coordinator was re-educated by theRegional MDS Consultant regarding timely completion of Admission MDS's within14 days of admission date. The MDS Coordinator will log AdmissionMDS's completed and communicate with the Director of nursing to sign daily. **4. How the corrective actions will be monitored:** The MDS schedule log will beaudited weekly to ensure all Admission MDS's were completed within 14 days ofadmission date. The Administrator and/orDirector of Nursing will be responsible for oversight of this audit. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months.	

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	conditions, skin conditions, medications, special treatments, procedures and programs were incomplete as of 10/30/15. During an interview, on 10/30/15 at 11:35 A.M., the MDS Coordinator indicated Resident #89 was admitted on 10/2/15, and the MDS admission assessment was not completed yet and it should be. 3.1-31(d)(1)		**1. Date of compliance: 12-4-15**	
F 0276 SS=D Bldg. 00	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure Quarterly MDS (Minimum Data Set) assessments were completed timely for 2 of 21 residents reviewed for assessments. (Residents #41 and #76) Findings include: 1. The clinical record for Resident #41 was reviewed on 10/28/2015 at 3:11 P.M. Resident #41 was admitted to the facility,	F 0276	**F 276** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or*	12/04/2015

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	on 01/14/15, with diagnoses, including but not limited to: Dysphasia, dementia with behavioral disturbance, aphasia, post traumatic seizures, morbid obesity duet o excess calories, gastroesophageal reflux, psuedobulbar affect, anxiety disorder, symbolic dysfunctions and hypothyroidism. The Quarterly MDS assessment indicated a scheduled completion date of 10/16/15. However, it was incomplete and still "in progress." 2. The clinical record for Resident #76 was reviewed on 11/02/2015 at 3:42 P.M. Resident #76 was admitted to the facility, on 07/02/15, with diagnoses, including but not limited to: urinary tract infection, dementia without behavioral disturbance, hypertension, heart failure, gastro-esophageal reflux, urine retention and osteoarthritis. The Admission MDS, had been completed on 07/12/15. The Quarterly MDS, which was scheduled to have been completed on 10/12/15, was incomplete and still "in progress." During an interview on 10/30/2015 at 2:31 P.M., the MDS coordinator, RN		*executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident#41, the MDS Assessment has been completed. Resident#76, the MDS Assessment has been completed. **2. How the facility identified other residentspotentially affected:** MDS schedule has been reviewed and allpast due MDS have been completed. **3.Measures put into place/systems changes:** The MDS Coordinator was re-educated by theRegional MDS Consultant regarding timely completion of MDS's. The MDS Coordinator will log MDS'scompleted and communicate with the Director of nursing to sign daily. **4. Howthe corrective actions will be monitored:** The MDS schedule log will beaudited weekly to ensure all MDS's were completed within appropriate time frame. The Administrator and/or Director of Nursingwill be responsible for oversight of this audit. The results of these auditswill be	

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	(Registered Nurse) #54, indicated she was aware of the late, incomplete MDS assessments, including the assessment for Resident #76 and indicated she was late. In addition, until very recently, she had been asked to help out providing nursing care on the floor due to staffing issues at the facility and the neighboring assisted living facility. She indicated she had asked the corporate consultant for help to assist her with an action plan to correct the issues she was experiencing. 3.1-31(d)(3)		reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance: 12-4-15**	
F 0279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are			

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	identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interviews, the facility failed to ensure care plans were initiated regarding fall risk for 1 of 3 residents reviewed for accidents. (Resident #90) and incontinence and/or toileting needs for 1 of 3 residents reviewed for incontinence. (Resident #89) In addition, the facility failed to ensure care plans regarding medication monitoring and behavior management were initiated for 5 of 7 residents receiving psychoactive medications in a sample of 8 residents whose medication use was reviewed. (Resident #90, #39, #20, #80 and #4) Findings include: 1. The clinical record for Resident #90 was reviewed on 10/28/15 at 2:00 P.M. Resident #90 was admitted to the facility, on 10/17/15, with diagnoses, including but not limited to Chronic Obstructive Pulmonary Disease.	F 0279	**F 279** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** 1.Resident#90, the care plan/kardex for fall risk and psychoactive medication/ behaviormonitoring have been completed. 2.Resident#39, the care plan/kardex for psychoactive medication/ behavior mood monitoringhas been completed. 3.Resident#4, the care plans for medication use (antidepressant,	12/04/2015

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	A Fall assessment completed, on 10/17/15, indicated Resident #90 scored 10, at high risk for falls. Nursing progress notes, dated 10/19/15 at 12:45 A.M. and 10/25/15 at 1:31 P.M., indicated Resident #90 had fallen. During an interview, on 10/28/2015 at 2:22 P.M., LPN (Licensed Practical Nurse)#57 indicted the only care plan in the chart for Resident #90 was for activities. There was no plan regarding the resident's fall risk or any interventions in place to prevent falls. She indicated perhaps the medical records office or the DON (Director of Nursing) had more care plans in their office but they (care plans) would not be assessable to staff. The current physician's orders for medication for Resident #90 included the medication, Buspairone (an antianxiety medication) 10 mg. (milligrams) twice a day per the gastrostomy tube and Cymbalta (an antidepressant) 60 mg one a day per the gastrostomy tube. The orders indicated the Buspairone was for depression and the Cymbalta was for pain. There were no care plans regarding the medication use and no specific tracking of anxiety for Resident #90.		anticoagulant, hypnotic,insulin, anti-hypertensive and pain medications) and behavior/mood monitoringhave been completed and added to kardex. 4.Resident#89, a toileting plan and incontinence care plan has been developed and interventions placed on the Kardex. 5.Resident#20, the psychoactive medication care plan and kardex have been updated toindicate behaviors and monitoring. 6.Resident#80, psychoactive medication care plan and kardex have been completed toindicate behaviors and monitoring. **1. How the facility identified other residentspotentially affected:** All residents that are incontinent,receive medications and identified as at risk for falls have the potential tobe affected. **2.Measuresput into place/systems changes:** Nursing staff will be re-educated onincontinence care, toileting and behavior monitoring according to care plan andKardex. Licensed nurses and Interdisciplinary teamhas be re-educated on developing interim care plans for identified risk areason admission assessment.	

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	During an interview, on 10/28/15 at 3:00 P.M., CNA (Certified Nursing Assistant) #64 indicated there was no specific information for Resident #90 in the Kardex. CNA #64 indicated because she had taken care of Resident #90 since she was admitted to the facility, she knew the resident required a two person transfer, was completely dependent for bathing and personal care needs, was fed via a tube and was to have nothing by mouth, and now had bed and chair alarms. CNA #64 was uncertain about the ambulatory status of Resident #90. CNA #64 indicated she was also not aware of any behavior issues or monitoring she was to perform for the resident. During an interview, on 10/29/15 at 9:41 A.M., CNA #55 indicated there were no specific behavior or mood monitoring indicated for Resident #90. She attempted to look for information on the Kardex but there was no information available for Resident #90. During an interview, on 11/02/15 at 9:10 A.M., LPN #65 indicated she was had only worked at the facility for two weeks and was not sure what behaviors were to be monitored for Resident #90. LPN #65 attempted to look at the medical diagnoses, which only listed Congestive		Interdisciplinary team has beenre-educated on completion of permanent care plan as identified in CAA sectionof MDS within 7 days of the initial comprehensive MDS completion. All resident care plans will be reviewedby Interdisciplinary team within 7 days after MDS completion to ensureappropriate care plans are in place as identified. This process will beongoing. **3.Howthe corrective actions will be monitored:** The Director of Nursing ordesignee will review new admission assessments the next business day followingadmission to ensure that an interim care plan has been completed for identifiedrisk areas. The Director of Nursing ordesignee will audit at least 3 residents per week who have had an MDS completedin the prior 7 days to ensure that appropriate care plans are in place. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance:** **12-4-15**	

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	Obstructive Pulmonary Disease. She looked at the current medication orders and noted the antianxiety medication but she could not locate a care plan with instructions on behavior monitoring. During an interview, on 10/28/2015 at 3:07 P.M., LPN #54 indicated there was only one care plan regarding activities for Resident #90 and nothing (care instructions or interventions) in the Kardex (electronic system for CNAs) She indicated on admission, the resident was to be assessed head to toe on the admission assessments, including a fall assessment. She indicated the admission nurse was supposed to initiate an interim care plan if prompted by need after completing the admission assessments. During an interview, on 11/02/15 at 10:40 A.M., LPN #60 indicated the nursing administrative team were supposed to initiate the care plans. She indicated interventions on the care plans would have then transferred onto the Kardex screen utilized by CNAs when providing care for residents. She indicated the facility no longer utilized paper assignment sheets with care instructions for CNAs they were just supposed to look at the Kardex for those instructions. She indicated administrative nursing staff were having			

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	to work on the floor due to staffing issues and shortages and care plans had just not gotten done 2. The clinical record for Resident #39 was reviewed on 11/02/2015 at 11:16 A.M. Resident #39 was admitted to the facility on 09/08/15 with diagnoses, including but not limited to: Malformation of coronary vessels, diabetes mellitus, anxiety disorder, COPD (Chronic Obstructive Pulmonary Disease), hyperlipidemia, chronic kidney disease stage 3, morbid obesity, heart failure, muscle wasting, diarrhea and difficulty walking. The current physician's orders for medication included the following psychoactive medications: Xanax (an antianxiety medication) .25 mg twice a day for anxiety, ordered on 10/19/15; Sertraline (an antidepressant medication) 150 mg once a day for anxiety state; Abilify (an antipsychotic mediation) 5 mg once a day for depression; Trazodone (an antidepressant medication) 150 mg at bedtime for depression; Valproic Acid (an antiseizure medication used for mood management) 250 mg for depression.			

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	There were no care plans for Resident #39 regarding his behaviors or psychoactive medication use. During an interview with the SSD, conducted on 11/02/15 at 3:07 P.M., she indicated there was no specific behavior tracking completed for Resident #39. She brought copies of the Kiosk tracking for an unspecific behavior for Resident #39 and either "not applicable" or "none of the above observed" was charted for every shift on every day. It was unclear when charring "none of the above observed" to what the staff were charting when no targeted medical symptom or behavior had been identified and there were no behavioral care plans for Resident #39. 3. On 10/30/15 at 1:30 P.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/18/15. The resident's diagnoses included, but were not limited to: aftercare following joint replacement surgery, diabetes type 2, dysphagia, cellulitis, adjustment disorder with depressed mood, edema, cardiac murmur and edema. The Medication Administration Record (MAR), dated 10/1/15 through 10/31/15, indicated the resident was being			

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	administered the following medications: ambien (a hypnotic) 5 milligrams (mg) at bedtime for insomnia, aspirin 325 mg daily for anticoagulant therapy, Potassium chloride 20 meq (milliequivalent) daily for peripheral vascular disease, Levemir Solution (Insulin) 20 units subcutaneous injection daily for insulin-dependant diabetes mellitus (IDDM), melatonin (a natural supplement to induce sleep) 3 mg at bedtime for insomnia, nortriptyline (antidepressant) 25 mg at bedtime for anxiety disorder, doxycycline 100 mg twice a day (BID) for cellulitis for 10 days (start date 10/21/15), Novolog insulin per sliding scale for IDDM and lasix (a diuretic) 20 mg BID for TIA (Transient Ischemic Attack). The Admission Minimum Data Set (MDS) assessment, dated 9/25/15, indicated the resident had no behaviors and had no symptoms of feeling depressed or trouble falling or staying asleep. The medication section section indicated the resident was receiving insulin, antidepressant, hypnotic, anticoagulant and a diuretic. The resident had no care plan for use of an antidepressant, anticoagulant, hypnotic, insulin, anti-hypertensive or pain medications.			

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	On 10/30/15 at 3:00 P.M., an interview was conducted with the Director of Nursing and MDS Coordinator. The DON (Director of Nursing) and MDS Coordinator both indicated care plans were developed by the Interdisciplinary Team. They could not explain why there were no care plans developed for Resident #4 regarding her medical concerns and/or medications. On 10/30/15 at 4:02 P.M., the Director of Nursing provided a policy titled "Care Plans Protocol, undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Regulation requires that care plans be completed or modified within 7 days of Completion date of comprehensive assessments... Upon completion of the Admission MDS, the MDS Coordinator and in [sic] disciplinary team will ensure that all triggered items are care planned and that any additional care plan needs are care planned...." 4. On 10/29/15 at 11:12 A.M., record review indicated, Resident #89 was admitted to the facility on 10/2/15, with diagnoses included, but were not limited to, "...sleep apnea, bronchitis, hyperlipidemia, and dementia with behavioral disturbance...."			

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	155702	A. BUILDING 00 B. WING	11/04/2015

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A Nursing Admission Assessment, dated 10/2/15, indicated the resident was frequently incontinent of bladder and the resident is wet once or more per shift during the day and night.

An Admission Interim Care Plan, dated 10/2/15, indicated: Incontinence Goals: Incontinence care provided/restore continence. Interventions: Assist/provide care as needed. Observe perineal area. There was no other care plan related to incontinence or toileting needs for Resident #89.

The Admission MDS (Minimum Data Set) assessment, dated 10/11/15, indicated Resident #89 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 5, required supervision of staff for transfers, and limited staff assistance for toilet use. The bladder and bowel assessment indicated the resident was occasionally incontinent and a toileting program had not been attempted. The Care Area Assessment (CAA) indicated the care area for urinary incontinence triggered for a care plan.

On 10/26/15 at 11:30 A.M., Resident #89 was seated in a chair in the lounge of the Touchstone dementia unit looking at a

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	magazine. He was dressed in a pair of plaid flannel pajama pants, the resident had a strong urine odor. At 11:45 A.M. the resident stood up from his chair and the back of his plaid pajama pants was saturated with urine from the buttock area down to his knees. On 10/26/15 at 2:42 P.M., Resident #89 was seated on a couch in the dementia unit in the lounge watching television. The resident had a strong urine odor, he was dressed in a pair of white cotton running shorts, the shorts had a large dried yellow stain on the front of them. On 10/27/15 at 10:00 A.M., Resident #89 came out of his room and indicated he just woke up for the day and was hungry, the resident ambulated over to the dining area and sat down at a dining room table. The resident had a strong urine odor, he was observed to have the same white cotton running shorts on as the previous day 10/26/15, the front of his shorts was saturated with urine. At 10:15 A.M., the resident ambulated from the dining room table to the lounge and sat down on the couch to read the newspaper. At 2:42 P.M., the resident still had the same white cotton shorts on, the front of the shorts had a large yellow stain, he was assisted by a CNA to the restroom, he was toileted and given a clean pair of			

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	pants to put on. During an interview, on 10/29/15 at 2:33 P.M., CNA #12 indicated Resident #89 was usually independent for toileting needs, but has known him to be incontinent at times. She further indicated she does not usually work on the dementia unit and wasn't familiar with this particular resident. She indicated when she works a new unit and is unfamiliar with the residents she looks at the kardex that is located on the electronic kiosk. She indicated the kardex tells her how much care a resident requires regarding Activites of Daily Living (ADL) and if the resident is incontinent. CNA#12 brought up the information regarding Resident #89 on the electronic Kardex the Kardex did not indicate the resident was incontinent. During an interview, on 10/30/15 at 11:35 A.M., the Minimum Data Set (MDS) Coordinator indicated she utilized nursing assessments and CNA documentation to complete her assessments. The MDS Coordinator further indicated she knows Resident #89 is incontinent and an incontinence care plan should have been developed but it was not. On 11/4/15 at 2:10 P.M., review of the			

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	undated current policy titled "Care Plans Protocol" received from the Director of Nursing indicated "...Establishing and Updating Care Plans: Admissions care plan will be initiated by admitting nurse...Upon completion of the Admission MDS, the MDS Coordinator and the interdisciplinary team will ensure that all triggered items are care planned and that any additional care needs are care planned...." 5. On 10/30/15 at 9:19 A.M., record review indicated, Resident #20 was admitted to the facility, on 7/15/15, with diagnoses included, but were not limited to, Parkinson's disease, restless leg syndrome, Alzheimer's disease, insomnia and delirium. The admission MDS (Minimum Data Set) assessment, completed on 7/25/15, indicated Resident #20 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 3. The assessment for behaviors indicated the resident was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. The Nursing Admission/Re-Admit Observation Assessment, dated 7/15/15, indicated under Section P			

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	Behavior/Mood: None noted was check marked. A Behavior Log, for August 2015, indicated the following: *On 8/9/15 at 1:59 P.M., wandering. *On 8/12/15 at 1:14 P.M., wandering. *On 8/13/15 at 1:46 P.M., resident kicking/hitting. *On 8/18/15 at 12:49 A.M., rejection of care during toileting. *On 8/19/15 at 1:14 A.M., rejection of care during toileting. *On 8/19/15 at 10:12 A.M., wandering. *On 8/21/15 at 10:24 A.M., resident kicking/hitting during toileting. *On 8/21/15 at 9:59 P.M., resident yelling/screaming. *On 8/23/15 at 10:25 A.M., resident kicking/hitting during personal hygiene. *On 8/24/15 at 4:50 A.M., rejection of care during toileting. *On 8/30/15 at 3:41 P.M., resident kicking/hitting. *On 8/31/15 at 12:34 A.M., rejection of care during toileting. A Behavior Log, for September 2015, indicated the following: *On 9/4/15 at 9:24 P.M., threatening behavior. *On 9/30/15 at 10:24 A.M., resident kicking/hitting during toileting.			

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	A behavior Log, for October 2015, indicated the following: *On 10/9/15 at 11:03 A.M., resident biting during toileting. *On 10/18/15 at 10:33 A.M., kicking/hitting during personal hygiene *On 10/29/15 at 3:52 A.M., pinching/scratching/spitting during toileting A nursing progress note, dated 10/10/15, indicated "...resident is pleasant and sitting in lounge with others...Whenever resident is restless, she usually needs to be toileted...." The quarterly MDS assessment, completed on 10/2515, indicated Resident #20 was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. On 10/29/15 at 9:28 A.M., Resident #20 was observed seated in a chair in the activity room, on the dementia unit, attending an activity, she was calm no behaviors observed. At 10:57 A.M., the resident was ambulated with the assist of 1 staff member to the television lounge, the resident was not resistant or combative, no delusional behaviors observed. At 11:40 A.M., the resident's son came into visit her and ambulated her			

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	to the dining room, she was quiet and calm. At 2:39 P.M., the resident was seated in a chair in the lounge with other residents eating a cupcake. No behaviors observed. During an interview, on 10/30/15 at 9:01 A.M., LPN #13 indicated Resident #20 gets agitated at times when the staff try to provide care. She indicated the resident frequently gets up out of her chair unassisted but redirection usually helps. She further indicated the resident has never had delusions. On 10/30/15 at 9:15 A.M., Resident #20 was awake and alert sitting in a chair in the activity room. At 10:45 A.M., a CNA was ambulating the resident in the hallway, the resident became resistant like she was trying to sit down in the hallway, at that time her son came to visit and assisted the resident into her room, she was placed in her recliner and resting quietly. At 1:30 P.M., the resident was resting quietly in her bed. At 2:45 P.M., the resident's bed alarm was alarming, a CNA entered the room to find the resident standing in the middle of the room unattended. The CNA assisted the resident into the lounge where she was resting quietly in a chair. On 10/30/15 at 9:37 A.M., review of a			

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	care plan, initiated on 7/21/15, indicated the focus: (resident name) uses antipsychotic/antidepressant medications r/t (related to) Alzheimer's disease and depression. Interventions included but were not limited to "...Administer medications as ordered. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Monitor for adverse effects every shift, notify MD as needed...." There was no other care plan related to target behaviors or monitoring of behaviors for Resident #20. During an interview, on 11/2/15 at 8:57 A.M., the Social Service Director indicated Resident #20 does not have any verbal aggression, she has had some recent physical aggression and some restlessness but she does not consider that a behavior. She further indicated the nursing staff keep repeatedly charting the resident is having a behavior when she gets up out of the chair unattended. The Social Service Director indicated the resident does not have any delusions and no behavior care plans were developed because she does not exhibit anything that she would consider a behavior. 6. A record review was conducted on 10/30/2015 at 11:34 A.M. for Resident #80. There were no care plans			

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	addressing behaviors or antipsychotic use observed for Resident #80. A nurse's note, dated 9/30/2015 at 7:54 P.M., indicated Resident #80 had been "...overly loud and unable to redirect with food and conversation. Continues to bang on table and yelling out. Gave haldol 1(ml) millliters for increased agitation...." A nurse's note, dated 10/5/2015 at 3:03 A.M., indicated that Resident #80 "...has been restless and anxious this shift. Resident has climbed out of bed greater than 7 times and refused to sit in wheelchair. After interventions of 1:1, toileting, and snack and repositioning for comfort Haldol injection was given in (RUOQ)right upper outer quadrant. Resident is resting quietly at this time....". On 11/02/2015 at 11:42 A.M., the Director of Nursing provided the current care plan policy titled "CARE PLANS PROTOCOL." The policy indicated "...Acute changes and order changes should be addressed on the care plan and are the responsibility of staff nurses to establish, revise, or discontinue care plan goal or interventions (i.e. acute orders - antibiotic, IV [intravenous], new drugs, change in orders, change in treatments, fall intervention, ect)...."			

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	During an interview on 10/30/2015 at 10:00 A.M., the Social Service Director indicated that she would provide all of the forms of behavior monitoring being completed on Resident #80 including the residents care plans. During a review of the requested information, there were no care plans observed to address the use of the antipsychotic medication. 3.1-35(a) 3.1-35(b)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure nail care was provided routinely for a dependent resident for 1 of 3 residents reviewed for ADL (activities of daily living) care. (Resident #59) In addition, the facility failed to ensure a toileting plan was followed for 1 of 3 residents reviewed for incontinence needs. (Resident #41) Findings include:	F 0282	**F282** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of*	12/04/2015

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	1. The clinical record for Resident #59 was reviewed on 10/29/2015 at 9:44 A.M. Resident #59 was admitted to the facility, on 07/29/13, with diagnoses, including but not limited to: Parkinson's disease, atrial fibrillation, history of falling, ataxia, contracture of the hands, MRSA (methacillin resistant staph aureous) infection, adjustment disorder with depressed mood, difficulty in walking and muscle weakness. The most recent Quarterly MDS (Minimum Data Set) assessment, completed on 08/12/15, indicated Resident #59 scored 12 of 15 on a BIMS (Brief Interview for Mental Status), cognitively intact. The resident was usually alert and oriented, required extensive staff assistance for transfer, dressing, personal hygiene and toilet use. The resident was totally dependent for bathing needs and had impaired range of motion on one side. The care plans for Resident #59 included a plan for refusing care, assist with toileting, requires two staff assist with bed mobility, On 10/27/15, Resident #59's hand were observed and his fingernails were noted to be very long, extending past the ends of his fingertips on both hands. His left		*federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #59, fingernails were trimmed. Resident #41, toileting plan and kardex werereviewed and updated. **2. How the facility identified other residentspotentially affected:** All resident's fingernails were assessedand trimmed as needed. All residents identified as incontinentaccording to the MDS have the potential to be affected. **3.Measuresput into place/systems changes:** Nursing staff were re-educatedon nail care to be provided with bathing/shower schedule and PRN, andincontinent care/ toileting needs to be provided according to care plan/kardex. **1.Howthe corrective actions will be monitored:** The Director of Nursing or designee willobserve 10 residents per week during rounds on varied shifts x30 days, then 5residents per week ensure nail care and incontinence care/ toileting needs areprovided according to plan of care. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3	

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	hand was noted to be contracted. Resident #59 observed on 10/29/2015 at 9:19:09 A.M. in his room, seated in his wheelchair. The resident had a splint on left hand, was awake and watching television. His fingernails were noted to be clean but very long. Resident #59's hands were observed on 10/30/15 at 8:42 A.M. His fingernails were still noted to be long and there was a soft blue splint on his left hand. An interview was attempted with Resident #59 regarding his nail care. He nodded "yes" when asked if he required assistance for nail care but just laughed when asked why his nails were so long or if staff were supposed to trim his nails. During an interview on 11/04/15 at 9:00 A.M., the DON (Director of Nursing) indicated if a dependent resident was not diabetic, the CNA (Certified Nursing Assistant) giving them a shower was responsible for nail care and should have trimmed Resident #59's nails if they needed to be trimmed. 2. The clinical record for Resident #41 was reviewed on 10/28/2015 at 3:11 P.M. .Resident #41 was admitted to the facility, on 01/14/15, with diagnoses, including but not limited to: dysphasia,		consecutive months. **1. Date of compliance:** **12-4-15**	

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	dementia with behavioral disturbance, aphasia, post traumatic seizures, morbid obesity, gastroesophageal reflux, psuedobulbar affect, anxiety disorder, symbolic dysfunctions and hypothyroidism. Resident #41's care plan related to incontinence, updated on 02/05/15, indicated the resident was to be toileted on an individualized schedule at 7:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M. and 7:00 P.M. The resident was to be allowed ample time for voiding, and was to be provided assistance with transfers, clothing adjustment and pericare during toileting. On 10/27/15 at 8:45 A.M., Resident #41 was observed seated at a dining table during the morning hours without any toileting. At 11:30 A.M., the resident was still noted to be seated at the dining room table and her outside pants were noted to be wet in the crotch area. The resident was noted to rock forward and the slam her back against the back of the dining room chair repeatedly. Another resident had gotten a pillow off of Resident #41's bed and placed it behind her back in the dining room chair. Staff were getting ready to serve the noon meal. She had not been observed to be toileted.			

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	On 10/29/2015 at 8:00 A.M., Resident #41 was observed seated in the West unit dining room at a table, wearing a T-shirt, plaid shorts, and geri sleeves on her arms. The resident remained in her dining chair, awake from 8:00 A.M. to 12:47 P.M. without being toileted. At 12:15 P.M., she was served her lunch by CNA #53. At 12:47 P.M., she was transferred to her wheelchair and pushed to be room by CNA #53 and #55., placed in bed and her wet brief was changed. She was not taken into the bathroom to sit on a toilet or given a bedpan. CNA #55 indicated sometimes Resident #41 was toileted. There was no explanation given as to why she had not been toileted during the morning hours on 10/29/15. On 10/30/2015 at 6:15 A.M., Resident #41 was observed, dressed and sitting in dining room on west hall dressed with unmatched socks. She remained in the dining table chair with no position changed from 6:15 A.M. to 8:57 A.M. She was noted to be awake and would rock forward and slam her back against the dining table chair repeatedly. At 8:57 A.M., CNA #50 and #52 transferred Resident #41 to her wheelchair, pushed her into her room and transferred her to a chair beside her bed. CNA #50 then left the room and returned at 9:05 A.M. CNA			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#50 changed Resident #41's socks and put matching socks on the resident. She indicated the 3rd shift had gotten Resident #41 up and dressed her. At 9:16 A.M., restorative CNA #56 entered the room and washed Resident #41's hands and proceeded to work with the resident's contracted hands. She said she was going to check with the other CNAs to see if the resident needed toileted. She indicated CNA #52 had informed her that Resident #41 was "dry," so CNA #56 did not toilet Resident #41. At 9:42 A.M., a family member came to visit with Resident #41 while she sat in her room in a chair beside her bed. Resident #41 remained in her chair without any toileting until 11:42 A.M., when she was transferred to her wheelchair by CNA #50 and pushed into the West unit dining room. At no point was Resident #41 given incontinence care and offered toileting before she was taken to the lunch table. At 1:15 PM., Resident #41 was observed lying in her bed awake. During an interview on 10/30/15 at 1:15 P.M. CNA #50 she indicated Resident #41 had been transferred to her bed and her brief changed around 12:50 P.M. She indicated the resident's brief had been wet when it was changed. On 10/30/15 at 10:00 A.M., an interview			

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	was conducted with CNA #50 and CNA #52, who were the only aides working on Resident #41's unit. Both CNAs indicated they were new to the facility and did not have an assignment sheet and did not have access to the electronic charting system. CNA #50 indicated it was her second day working on the floor, she had oriented on another unit, and she was unaware of any toileting plan for Resident #41. 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interviews, the facility failed to ensure nail care was provided for 1 of 3 residents reviewed for ADL (Activities of daily living) needs. (Resident #59) Finding includes: The clinical record for Resident #59 was reviewed on 10/29/2015 at 9:44 A.M. Resident #59 was admitted to the facility,	F 0312	**F 312** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of*	12/04/2015

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	on 07/29/13, with diagnoses, including but not limited to: Parkinson's disease, atrial fibrillation, history of falling, ataxia, contracture of the hands, MRSA (methacillin resistant staph aureous) infection, adjustment disorder with depressed mood, difficulty in walking and muscle weakness. The most recent Quarterly MDS (Minimum Data Set) assessment, completed on 08/12/15, indicated Resident #59 scored 12 of 15 on a BIMS (Brief Interview for Mental Status), cognitively intact. The resident was usually alert and oriented and required extensive staff assistance personal hygiene. The resident was totally dependent for bathing needs and had impaired range of motion on one side. The care plans for Resident #59 included a plan for refusing care. On 10/27/15, Resident #59's hand were observed and his fingernails were noted to be very long, extending past the ends of his fingertips on both hands. His left hand was noted to be contracted. Resident #59 observed, on 10/29/2015 at 9:19 A.M., in his room, seated in his wheelchair. The resident had a splint on left hand, was awake and watching		*correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #59, nails were trimmed. **2. How the facility identified other resident:** All resident's nails were assessed andtrimmed as needed. **3.Measuresput into place/systems changes:** Nursing staff were re-educatedon nail care to be provided with bathing/shower schedule and PRN **1.Howthe corrective actions will be monitored:** TheDirector of Nursing or designee will observe 10 residents per week duringrounds on varied shifts x30 days, then 5 residents per week thereafter toensure nail care is provided. Theresults of these audits will be reviewed in the Quality Assurance meetingmonthly until 100% compliance is achieved x3 consecutive months. **2. Date of compliance:** **12-4-15**	

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	television. His fingernails were noted to be clean but very long. Resident #59's hands were observed on 10/30/15 at 8:42 A.M. His fingernails were still noted to be long and there was a soft blue splint on his left hand. An interview was attempted with Resident #59 regarding his nail care. He nodded "yes" when asked if he required assistance for nail care but just laughed when asked why his nails were so long or if staff were supposed to trim his nails. During an interview, on 11/04/15 at 9:00 A.M., the Director of Nursing indicated if a dependent resident was not diabetic, the CNA (Certified Nursing Assistant) giving them a shower was responsible for nail care and should have trimmed Resident #59's nails if they needed to be trimmed. 3.1-38(a)(3)(E)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless			

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	the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interviews, the facility failed to ensure there was a thorough bladder incontinence assessment for 1 of 3 residents reviewed for incontinence. (Resident #89) In addition, the facility failed to follow a toileting plan for 1 of 3 residents reviewed for incontinence. (Resident #41) Findings include: 1. The clinical record for Resident #41 was reviewed on 10/28/2015 at 3:11 P.M. Resident #41 was admitted to the facility, on 01/14/15, with diagnoses, including but not limited to: dysphasia, dementia with behavioral disturbance, aphasia, post traumatic seizures, morbid obesity, psuedobulbar affect, anxiety disorder, symbolic dysfunctions and hypothyroidism. A Quarterly MDS assessment, completed on 09/26/15, indicated the resident was severely cognitively impaired, required extensive staff assistance for transfers and toilet use, and was always	F 0315	**F 315** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident#41-The care plan and toileting program has been reviewed and updated to meetresidents care needs. Resident#89- Bladder assessment has been completed and the care plan reflects theresidents' toileting program. **2. How the facility identified other residentspotentially affected:** All residents identified as incontinent according to theMDS have the potential to be affected.	12/04/2015

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	incontinent of her bowels and bladder. A bowel and bladder assessment, completed on 04/22/15, indicated the resident was frequently incontinent of her bowels and bladder and required extensive staff assistance for toileting. The care plan related to incontinence, updated on 2/05/15, indicated the resident was to be toileted on an individualized schedule at 07:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M. and 7:00 P.M. The resident was to be allowed ample time for voiding, and was to be provided assistance with transfers, clothing adjustment and pericare during toileting. Resident #41 was observed, on 10/27/15 at 8:45 A.M., seated at a dining table during the morning hours without any toileting. At 11:30 A.M., the resident was still noted to be seated at the dining room table and the outside of her pants were noted to be wet in the crotch area. The resident was noted to rock forward and then slam her back against the back of the dining room chair repeatedly. Another resident had gotten a pillow off of Resident #41's bed and placed it behind her back in the dining room chair. Staff were getting ready to serve the noon meal. She had not been observed to be		An audit will be completed to identify residents who havenot had a bladder assessment completed in the last 3 months. **1.Measuresput into place/systems changes:** Nursing staff were re-educatedon incontinent care/ toileting needs to be provided according to careplan/kardex. The MDS/Restorative nurse willcomplete a bladder assessment on new admissions within 7 days of admission,then quarterly thereafter or with significant change in bladder continence. **1.How the corrective actions will bemonitored:** The Director of Nursing or designee willobserve 10 residents per week during rounds on varied shifts x30 days, then 5residents per week thereafter to ensure incontinence care/ toileting needs areprovided according to plan of care. The Director of Nursing ordesignee will audit all new admissions and at least 3 residents per week whohave had an MDS completed in the prior 7 days to ensure that a recent bladderassessment has been completed and care plans and toileting programs are inplace as indicated. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months.	

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	toileted before the meal was served. On 10/29/2015 at 8:00 A.M., Resident #41 was observed seated in the West unit dining room at a table. The resident remained in her dining chair, awake from 8:00 A.M. to 12:47 P.M. without being toileted. At 12:15 P.M. she was served her lunch by CNA (Certified Nursing Assistant) #53. At 12:47 P.M., she was transferred to her wheelchair and pushed to her room by CNA #53 and 55., placed in bed and her wet brief was changed. She was not taken into the bathroom to sit on a toilet or given a bedpan. CNA #55 indicated sometimes Resident #41 was toileted. There was no explanation given as to why she had not been toileted during the morning hours on 10/29/15. On 10/30/2015 at 6:15 A.M., Resident #41 was observed, dressed, sitting in dining room on west hall dressed with unmatched socks. She remained in the dining table chair with no position changed from 6:15 A.M. to 8:57 A.M. She was noted to be awake and would rock forward and slam her back against the dining table chair repeatedly. At 8:57 A.M., CNA #50 and #52 transferred Resident #41 to her wheelchair, pushed her into her room, and transferred her to a chair beside her bed. CNA #50 then left the room and returned at 9:05 A.M. and		**1. Date of compliance:** **12-4-15**	

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	changed Resident #41's socks and put matching socks on the resident. She indicated the 3rd shift had gotten Resident #41 up and dressed her. At 9:16 A.M., restorative CNA #56 entered the room and washed Resident #41's hands and proceeded to work with the resident's contracted hands. She said she was going to check with the other CNAs to see if the resident needed toileted. She indicated CNA #52 had informed her that Resident #41 was "dry." CNA #56 did not toilet Resident #41. At 9:42 A.M., a family member came to visit with Resident #41 while she sat in her room in a chair beside her bed. Resident #41 remained in her chair without any toileting until 11:42 A.M., when she was transferred to her wheelchair by CNA #50 and pushed into the West unit dining room. At no point was Resident #41 given incontinence care or offered toileting before she was taken to the lunch table. At 1:15 PM., Resident #41 was observed lying in her bed awake. During an interview on 10/30/15 at 1:15 P.M., CNA #50 indicated Resident #41 had been transferred to her bed and her brief changed around 12:50 P.M. She indicated the resident's brief had been wet when it was changed. On 10/30/15 at 10:00 A.M., an interview			

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	with CNA #50 and CNA #52 was conducted. Both were the only aides working on Resident #41's unit. Both CNAs indicated they were new to the facility and did not have an assignment sheet and did not have access to the electronic charting system. CNA #50 indicated it was her second day working on the floor, she had been oriented on another unit, and she was unaware of any toileting plan for Resident #41. 2. On 10/29/15 at 11:12 A.M., record review for Resident #89 was conducted. Resident #89 was admitted to the facility on 10/2/15, with diagnoses included, but were not limited to, sleep apnea, bronchitis, hyperlipidemia, and dementia with behavioral disturbance. A Nursing Admission Assessment, dated 10/2/15, indicated the resident was frequently incontinent of bladder and the resident was wet once or more per shift during the day and night. An Admission Interim Care Plan, dated 10/2/15, indicated: Incontinence Goals: Incontinence care provided/restore continence. Interventions: Assist/provide care as needed. Observe perineal area. There was no other care plan related to incontinence or toileting needs for Resident #89.			

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The Admission MDS (Minimum Data Set) assessment, dated 10/11/15, indicated Resident #89 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 5. Resident #89 required supervision of staff for transfers, and limited staff assistance for toilet use. The bladder and bowel assessment indicated the resident was occasionally incontinent and a toileting program had not been attempted. The Care Area Assessment (CAA) indicated the care area for urinary incontinence triggered for care planning.

A 72 Hour Admit/Re-Admit Charting, dated 10/4/15, indicated the resident was independent of toilet use and required no setup or physical help from staff.

A 72 Hour Admit-Re-Admit Charting, dated 10/6/15, indicated the resident required total dependence for toilet use and was a one person physical assist.

A Bowel and Bladder Elimination Record, dated October 2015, indicated the resident was incontinent of bladder one time on 10/9/15, one time on 10/19/15 and one time on 10/26/15 at 21:59 (9:59 P.M.).

On 10/26/15 at 11:30 A.M., Resident #89

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	was observed seated in a chair, in the lounge of the Touchstone dementia unit, looking at a magazine. He was dressed in a pair of plaid flannel pajama pants, the resident had a strong urine odor. At 11:45 A.M., the resident stood up from his chair and the back of his plaid pajama pants was observed to be saturated with urine from the buttock area down to his knees. On 10/26/15 at 2:42 P.M., Resident #89 was observed seated on a couch, in the dementia unit in the lounge watching television. The resident had a strong urine odor, he was dressed in a pair of white cotton running shorts, the shorts had a large dried yellow stain on the front of them. On 10/27/15 at 10:00 A.M., Resident #89 was observed coming out of his room. The resident indicated he just woke up for the day and was hungry, the resident ambulated over to the dining area and sat down at a dining room table. The resident had a strong urine odor, he was observed to have the same white cotton running shorts on as the previous day 10/26/15, the front of his shorts was saturated with urine. At 10:15 A.M., the resident ambulated from the dining room table to the lounge and sat down on the couch to read the newspaper. At 2:42 P.M., the			

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	resident still had the same white cotton shorts on, the front of the shorts had a large yellow stain, he was assisted by a CNA to the restroom, he was toileted and given a clean pair of pants to put on. During an interview, on 10/29/15 at 2:33 P.M., CNA #12 indicated Resident #89 was usually independent for toileting needs, but has known him to be incontinent at times. She further indicated she does not usually work on the dementia unit and wasn't familiar with this particular resident. She indicated when she works a new unit and is unfamiliar with the residents she looks at the kardex that is located on the electronic kiosk. She indicated the kardex tells her how much care a resident requires regarding Activities of Daily Living (ADL) and if the resident is incontinent. CNA#12 brought up the information regarding Resident #89 on the electronic Kardex system. The Kardex did not indicate the resident was incontinent. During an interview, on 10/30/15 at 11:35 A.M., the Minimum Data Set (MDS) Coordinator indicated she utilized nursing assessments and CNA documentation to complete her assessments. The MDS Coordinator further indicated she knows Resident #89			

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	is incontinent and an incontinence care plan should have been developed but it was not. During an interview, on 11/4/15 at 1:49 P.M., the Director of Nursing indicated she was not able to locate an incontinence assessment for Resident #89. On 11/4/15 at 2:00 P.M., review of the current policy titled "Toileting Program," dated 6/4/12, received from the Director of Nursing, indicated "...To reduce resident incontinence episodes and restore as much bowel and bladder incontinence [sic] as possible by trying to identify a voiding pattern and implement a toileting program. An incontinent program, prompted voiding, scheduled toileting, or check and change program will be implemented based on resident assessment, medical history, medication and information obtained from resident, family and staff...Procedure: If the resident has been identified as being incontinent: 1. The incontinence assessment will be completed by the licensed nurse after 72 hours, but within 7 days, of admission and significant resident changes. 2. Resident incontinence episodes will be documented by the CNA for 3 days, for admissions and significant resident			

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	changes...3. The restorative nurse will review resident assessments...4. The restorative nurse will implement the appropriate toileting program based on the resident's assessment and data. 5. The resident's plan of care will be developed to address the issue(s), goals and appropriate interventions for elimination program, using an interdisciplinary team approach...." 3.1-41(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure fall interventions were care planned and implemented timely to prevent falls for 2 of 3 residents reviewed for falls. (Resident #90 and Resident #18) Finding includes: 1. The clinical record for Resident #90 was reviewed on 10/28/15 at 2:00 P.M. Resident #90 was admitted to the facility	F 0323	**F 323** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or*	12/04/2015

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	155702	A. BUILDING 00 B. WING	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	on 10/17/15 with diagnoses, including but not limited to Chronic Obstructive Pulmonary Disease. A fall risk assessment, completed on 10/17/15, indicated the resident scored 10 points, high risk for falls. There was no care plan noted in the clinical record for Resident #90 related to falls. During an interview, on 10/28/2015 at 2:22 P.M., LPN (Licensed Practical Nurse) #57 indicted the only care plan in the electronic chart was for activities. She indicated Medical records or the DON (Director of Nursing) might have some in their office but it would not be assessable to staff. A nursing progress note, dated 10/19/15 at 12:45 A.M., indicated the resident was found on the floor beside her bed. A fall IDT (Interdisciplinary Team) progress note, dated 10/19/15, indicated an assessment was to be completed and a mat placed at the bedside for safety. The note also indicated the care plan was updated. A nursing progress note, dated 10/25/15 at 1:31 P.M., indicated the resident had		*executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #90- the care plan/kardex forfall risk has been completed. Resident #18- falls have beenreviewed and fall risk care plan/ kardex have been updated. **1. How the facility identified other residentspotentially affected:** All residents at risk for falls have thepotential to be affected. **2.Measuresput into place/systems changes:** Licensed nurses will bere-educated on implementing interim fall risk care plans on admission andupdating fall care plans with appropriate fall interventions after each fall. **1.Howthe corrective actions will be monitored:** The interdisciplinary team will review allfalls on the next business day after the fall to ensure appropriateintervention was implemented and added to the care plan/kardex. The Director of Nursing ordesignee will audit new admissions who had an MDS completed in the prior 7 daysto ensure that appropriate care plan	

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	been in her room, in her wheelchair watching television and called out for help. The resident was found sitting on the floor on her buttocks. Resident stated she was trying to get up to get the telephone. She indicated she hit her head and right shoulder on the wheelchair. Nursing notes following Resident #90's second fall documented a chair alarm, padded mats beside her bed, a bed alarm and low bed. Resident #90 was observed on 10/29/15 at 10:30 A.M., sitting in her wheelchair, in her room, with the wound care nurse, LPN #57. The resident had gripper socks on her feet and the wheelchair alarm was on her wheelchair. At 10:45 A.M. the chair alarm for Resident #90 sounded and the LPN #58, who was on the phone ran into the resident's room to tell her to sit back in her chair. The resident had been attempting to get out of her wheelchair. CNA (Certified Nursing Assistant) #53 then entered the room carrying a quilted bed pad. CNA #53 was then observed to transfer resident by herself from her wheelchair to her bed and provided incontinence care. The resident's legs, shoulder, elbow were noted to have extensive bruises. CNA #53 indicated she had only worked for about 2 weeks at the facility and the resident had those		was developed within 7 days after MDScompletion. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance:** **12-4-15**	

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	bruises. She indicated she had noted the bruising on a shower sheet and notified the nurse. The CNA indicated the resident she did not think the bruising was from a fall. She indicated she did know that the resident had not fallen since she had been admitted. The resident was able to stand and support her weight and follow instructions for transferring and rolling in bed. The resident was noted to be very impulsive in between instructions and tried to help herself reposition at times. Resident was then left in her room in a low bed with 1/4 side rails, bed alarm and mats on both sides of her bed. On 10/29/2015 at 12:18 P.M., Resident #90 was observed seated in wheelchair by nurses station facing all the resident's eating in the dining room. She was noted to have unplugged her g-tube (gastrostomy) tubing and had liquid g-tube on her hand and a little on her pants. LPN #57 walked out of a room and reattached the tube feeding and said "we'll have to change your clothes." LPN #578 did not change her clothes. The resident was then left alone and eventually was noted pulling on g-tube machine and tubing. Resident #90 observed on 10/29/2015 at 2:33 P.M. seated in her wheelchair by the			

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	nurse's station. There was a wheelchair alarm noted on her wheelchair. Her feet were on wheelchair pedals and she was wearing nonskid socks. Resident #90 was observed on 10/29/2015 at 2:41 P.M., seated in her wheelchair by the nurse's station, very fidgety, pulling at her g-tube tubing, reaching for her wheelchair pedals and grabbing at her clothing. LPN #59 was noted to continually have to attempt to redirect Resident #90 and have her sit back in her wheelchair as she kept triggering her chair alarm. Resident #90 was wondering where her mother was and stated she needed to get up, go home and fix supper for her dad. In addition, she kept trying to answer the Bingo caller, which was the activity on the West unit. During an interview, on 10/28/2015 at 3:07 P.M., the MDS coordinator, LPN #54, indicated there was only one care plan for activities for Resident #90 and nothing in the Kardex, which was where any instructions including fall interventions would show up. She indicated on admission, the resident was to be assessed head to toe on the admission assessments, including a fall assessment. If needed there was supposed to be a prompt and the nurse			

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	who completed the admission assessments was supposed to care plan any needed issues. A nursing progress notes, dated 10/30/15 at 6:35 P.M., indicated the resident's alarm was sounding and staff found resident on the ground. The resident had been in her bed. There was still no care plan in place regarding her fall risk. During an interview, on 11/02/2015 at 10:40 A.M., the Unit Manager, LPN #60, indicated although there was no care plan and it was not charted, on admission they initiated a bed alarm. After the resident fell out of bed on 10/19/15, the IDT team added mats beside the resident's bed as an intervention. After the resident fell on 10/25/15 out of her wheelchair, there was no IDT (interdisciplinary team) note, still no care plan and they added nonskid footwear. She indicated she thought the resident already had a chair alarm in place. It was unclear when or if a chair alarm had been initiated before the 10/19/15 fall or the 10/25/15 fall as there was no mention of an alarm sounding on either fall investigation forms. LPN #60 indicated the IDT (interdisciplinary team) should have care planned the fall risk and updated the care plan with the interventions but due to staff shortages			

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	and the unit manager having to help out working on the floor, the care plan and the investigations were not completed as they have been. The unit manager indicated if the fall interventions were not care planned and not on the Kardex then they would not be available for staff working on the floor. She also indicated there was a way for the admitting nurse to initiate generic interim care plans but it was unclear why no plans were initiated for Resident #90. 2. During an interview on 10/27/2015 at 2:34 P.M., Resident #18 indicated that she slid out of her chair trying to put her shoes on. The clinical record for Resident #18 was reviewed on 11/01/2015 at 6:58 P.M. A nurses note, dated 9/2/2015 at 10:36 p.m., indicated Resident #18 was attempting to scoot herself down the hallway in her wheelchair and slid off onto the floor on her buttock. A care plan was added on 9/17/2015, and indicated a new intervention was to "...remind resident to keep legs elevated when sitting in a recliner, remind resident to sit back in her seat while sitting in her wheelchair...." A nurse's note, dated 9/23/2015 at 11:03			

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	A.M., indicated "...Writer responded to alarm resident was found sitting on floor in front of wheelchair had been attempting to stand lean across bed and push call light legs became weak and resident sat on the floor using bed rail to ease self down, fall was unwitnessed, neuro checks initiated [physician] notified.... No injury noted resident denies pain...." A nurse's note, dated 9/26/2015 at 4:55 P.M., indicated that resident wheeled self into restroom then attempted to transfer self to toilet without staff assistance. Resident was found sitting upright in front of wheelchair next to commode. A care plan indicated an intervention, dated 9/28/2015, for non skid foot wear and to do an environmental sweep for obstacles and ensure call light is reachable. A nurse's note indicated on 10/16/2015 at 3:12 P.M., Resident #18 was "... leaning forward to reach something out of a tote box and slid out of her chair onto the floor on her bottom. A minute later resident was trying to transfer self to the toilet and slid out of wheelchair onto the floor. No injuries noted, No complaints of pain. Resident has been very anxious today. Faxed [physician] requesting an			

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	antianxiety medication to see if this helps...." A care plan intervention, dated 10/19/2015, indicated that Resident #18 was to be receiving a restorative program and a review is to be conducted in a behavioral meeting quarterly and PRN (as needed). On 10/30/15 at 8:35 A.M., written documentation, received from the Director of Nursing, indicated that the Resident #18 had fell five times in the last three months. On 11/02/2015 at 11:42 A.M., the Director of Nursing provided the current care plan policy titled "CARE PLANS PROTOCOL." The policy indicated "...Acute changes and order changes should be addressed on the care plan and are the responsibility of staff nurses to establish, revise, or discontinue care plan goal or interventions (i.e. acute orders - antibiotic, IV [intravenous], new drugs, change in orders, change in treatments, fall intervention, ect)...." On 10/30/2015 at 3:12 P.M., the Director of Nursing provided the current fall policy titled, "FALL EVALUATION and INVESTIGATION," dated 8/2013. The policy indicated "...2. Complete the			

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	investigation to determine the root cause of the fall...." and "...4. Update the Care Plan to reflect any new interventions added...." 3.1-45(a)(2)			
F 0329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review and interviews the facility failed to ensure there were adequate indications to support the use of antianxiety medication	F 0329	**F 329** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the*	12/04/2015

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	for 1 of 8 residents reviewed (Resident #39) and psychotropic medications for 1 of 8 residents reviewed for medication use (Resident #20) In addition, the facility failed to ensure there was adequate monitoring of targeted behavioral symptoms requiring the use of psychoactive medications for 6 of 7 residents reviewed for unnecessary medication use who were receiving psychoactive medications. (Resident #20, #4, #39, #47, #80 and #90) Findings include: 1. The clinical record for Resident #47 was reviewed on 11/02/2015 at 9:23 A.M. Resident #47 was admitted to the facility, on 05/02/14, with diagnoses, including but not limited to:status post acute myocardial infarction, muscle weakness, difficulty in walking, diabetes mellitus, hypertension, hypothyroidism, vascular dementia with behavioral disturbances, adjustment disorder with depressed mood, psychosis, and muscle washing and atrophy. The current physician's orders for medications included the following psychoactive medications: Risperdal (an antipsychotic medication) 0.25 mg (milligrams) twice a day related to a delusional disorder;		*center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident#47, #90, #4, #80- Care plan and kardex have been reviewed and updated toinclude targeted behaviors. Resident#39- Resident reported to physician on 10/3/15 during visit subjectivecomplaints of increased uncontrolled anxiety and insomnia, which prompted thephysician to add Xanax 0.25mg BID to start 10/4/15. The facility and physicianfeel that although resident does not show outward physical signs of anxiety orbehaviors that staff may observe, his report of subjective feelings of anxietyfor over 10 years and self-reported recent increase in symptoms justify use ofXanax. The care plan and kardex havebeen reviewed and updated to include targeted behaviors and mood symptoms. Resident#20- Medication review was conducted by physician 0n	

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	Celexa 20 mg once a day for depressive disorder. Resident #47 had a care plan related to her vascular dementia with delusions. The care plan indicated her delusions were often regarding people taking her things, that she was to leave the facility, or that Jesus told her she was dying. The Kardex (electronic charting system) for Resident #47, with information regarding behavior tracking for the CNA staff, indicated the resident was to be monitored for pacing, wandering, inappropriate response to verbal communication, violence/aggression towards others/staff and disrobing. During an interview, on 11/02/15 at 12:30 P.M., the Social Service Director (SSD) indicated the Kardex information with targeted behaviors was incorrect for Resident #47. During an interview, on 11/02/15 at 2:30 P.M., CNA (Certified Nursing Assistant) #62 indicated she was not aware of any behaviors being monitored for Resident #47. During an interview, on 11/02/15 at 2:32 P.M., LPN (Licensed Practical Nurse) #59 indicated the resident will talk to		10/30/15 and Seroquel(quetiapine) dosage was reduced from 50mg BID to 25mg BID. Care plans and thekardex were updated to include targeted behaviors. **2.Howthe facility identified other residents potentially affected:** A review of care plans andkardex for all resident's receiving psychoactive medications for behaviors willbe completed. **1. Measures put into place/systems changes:** Nursing staff were educated onthe Behavior Management Program Binders, use of Kardex to indicate residentspecific behaviors and interventions and monitoring/documentation of behaviors. The Social Service Director ordesignee will review at least 5 residents per week receiving psychoactive medications to ensurebehavior management program is in place, behavior documentation is reviewed andcare plans/ Kardex are updated to include targeted behavior symptoms until allresidents have been reviewed. Thisprocess will be ongoing on at least a quarterly basis thereafter duringBehavior Management/GDR Review meetings. The Social Service Directorand/or Director of Nursing will review all new psychoactive medication	

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	someone who is not there all the time but she does not consider that a behavior but rather a part of her dementia. LPN #59 indicated the resident used to be on the dementia unit and so she exhibits signs and symptoms of dementia. 2. The clinical record for Resident #39 was reviewed on 11/02/2015 at 11:16 A.M. Resident #39 was admitted to the facility, on 09/08/15, with diagnoses, including but not limited to: Malformation of coronary vessels, diabetes mellitus, anxiety disorder, COPD (chronic obstructive pulmonary disease), hyperlipidemia, chronic kidney disease stage 3, morbid obesity, heart failure, muscle wasting, diarrhea and difficulty walking. The current physician's orders for medication included the following psychoactive medications: Xanax (an antianxiety medication) 0.25 mg twice a day for anxiety, ordered on 10/19/15; Sertraline (an antidepressant medication) 150 mg once a day for anxiety state; Abilify (an antipsychotic mediation) 5 mg once a day for depression; Trazodone (an antidepressant medication) 150 mg at bedtime for depression; Valproic Acid (an antiseizure medication		ordersduring clinical meeting and ensure a behavior management program andcommunication is in place. **1.Howthe corrective actions will be monitored:** The results of these auditswill be reviewed in Quality Assurance meeting monthly until 100% compliance isachieved x3 consecutive months. **1. Date of compliance:12-4-15**	

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	utilized for mood management) 250 mg for depression. There were no care plans for Resident #39 regarding his behaviors or psychoactive medication use. During an interview, on 11/02/2015 at 2:20 P.M., LPN #58 indicated the resident did not have any behaviors that they (nursing staff) track. When queried as to why an antianxiety medication was initiated on 10/19/15, she indicated she thought that was "weird" as the resident did not ever seem anxious to her. She indicated the resident preferred to stay in his room but he was talkative and liked to tease when staff entered his room. During an interview, on 11/02/15 at 2:23 P.M., LPN #65 indicated the resident occasionally requested breathing treatments but did not display any signs and symptoms of anxiety or depression. She indicated she thought the resident preferred to stay in his room and sleep. During an interview, on 11/02/2015 at 3:13 P.M., the Social Service Director (SSD), indicated she was not sure why the resident was started on Xanax. She indicated he exhibited some depression symptoms but not anxiety.			

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	There were no care plans for Resident #39 regarding his behaviors or psychoactive medication use. During an interview with the SSD, conducted on 11/02/15 at 3:07 P.M., she indicated there was no specific behavior tracking completed for Resident #39. She brought copies of the Kiosk (electronic charting system) tracking for an unspecific behavior for Resident #39 and either "not applicable" or "none of the above observed" was charted for every shift on every day. It was unclear when charting "none of the above observed' to what the staff were charting when no targeted medical symptom or behavior had been identified and there were no behavioral care plans for Resident #39. The transfer orders from a previous long term care facility were reviewed on 11/02/15 at 3:15 P.M. with the SSD. The orders indicated the resident had been receiving the Abilify due to severe recurrent major depression refractory, the Valproic Acid was given for headaches, the Zoloft was given for depression, and the Trazodone was given for Insomnia. The SSD indicated she was not aware of the previous diagnoses for Resident #39. She indicated the facility psychiatric nurse practitioner had assessed Resident #39 and she had ordered the Xanax. It was unclear if the nurse practitioner was			

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aware of the previous medical symptoms for which the resident's current psychoactive medications were given. There was no monitoring for insomnia, headaches, depression and/or anxiety issues.

3. The clinical record for Resident #90 was reviewed on 10/28/15 at 2:00 P.M. Resident #90 was admitted to the facility, on 10/17/15, with diagnoses, including but not limited to Chronic Obstructive Pulmonary Disease.

During an interview, on 10/28/2015 at 2:22 P.M., LPN #57 indicted the only care plan in the chart for Resident #90 was for activities. She indicated perhaps the medical records office or the DON had more care plans in their office but they (care plans) would not be assessable to staff.

In addition,the current physician's orders for medication for Resident #90 included the medication, Buspairone 10 mg (an antianxiety medication) twice a day per the gastrostomy tube and Cymbalta (an antidepressant) 60 mg one a day per the gastrostomy tube. The orders indicated the Buspairone was for depression and the Cymbalta was for pain.

There were no care plans regarding the

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	medication use and no specific tracking of anxiety for Resident #90. During an interview, on 10/28/15 at 3:00 P.M., CNA #64 indicated there was no specific information for Resident #90 in the Kardex. CNA #64 indicated because she had taken care of Resident #90 since she was admitted to the facility. CNA #64 indicated she was not aware of any behavior issues or monitoring she was to perform for the resident. During an interview, on 10/29/15 at 9:41 A.M., CNA #55 indicated there were no specific behavior or mood monitoring indicated for Resident #90. She attempted to look for information on the Kardex but there was no information available for Resident #90. During an interview, on 11/02/15 at 9:10 A.M., LPN #65 indicated she was had only worked at the facility for two weeks and was not sure what behaviors were to be monitored for Resident #90. LPN #65 attempted to look at the medical diagnoses, which only listed Congestive Obstructive Pulmonary Disease. She looked at the current medication orders and noted the antianxiety medication but she could not locate a care plan with instructions on behavior monitoring.			

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	During an interview, on 10/28/2015 at 3:07 P.M., the MDS (Minimum Data Set) Coordinator-LPN #54 indicated there was only one care plan regarding activities for Resident #90 and nothing (care instructions or interventions) in the Kardex (electronic system for CNAs) During an interview, on 11/02/15 at 10:40 A.M., LPN #60 indicated the nursing administrative team were supposed to initiate the care plans. She indicated interventions on the care plans would have then transferred onto the Kardex screen utilized by CNAs when providing care for residents. She indicated the facility no longer utilized paper assignment sheets with care instructions for CNAs they were just supposed to look at the Kardex for those instructions. She indicated administrative nursing staff were having to work on the floor due to staffing issues and shortages and care plans had just not gotten done 4. On 10/30/15 at 1:30 P.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/18/15. The resident's diagnoses included, but were not limited to: aftercare following joint replacement surgery, diabetic, dysphagia, cellulitis, adjustment disorder with depressed mood, edema, cardiac murmur			

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	and edema. The Medication Administration Record (MAR), dated 10/1/15 through 10/31/15, indicated the resident was being administered the following medications: ambien (a hypnotic) 5 milligrams (mg) at bedtime for insomnia, aspirin 325 mg daily for anticoagulant therapy, Potassium chloride 20 meq (milliequivalent) daily for peripheral vascular disease, Levemir Solution (Insulin) 20 units subcutaneous injection daily for insulin-dependant diabetes mellitus (IDDM), melatonin 3 mg at bedtime for insomnia, nortriptyline (antidepressant) 25 mg at bedtime for anxiety disorder, doxycycline 100 mg twice a day (BID) for cellulitis for 10 days (start date 10/21/15), Novolog insulin per sliding scale for IDDM and lasix (diuretic) 20 mg BID for TIA (Transient Ischemic Attack). The Admission Minimum Data Set (MDS) assessment, dated 9/25/15, indicated the resident had no behaviors and had no symptoms of feeling depressed or trouble falling or staying asleep. The medication section section indicated the resident was receiving insulin, antidepressant, hypnotic, anticoagulant and a diuretic. The Care Area Assessment indicated psychotropic			

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	drug use. The resident had no care plan for the use of an antidepressant, anticoagulant, hypnotic, insulin, anti-hypertensive or pain medications. A form titled "Monitor - Behavior Symptoms," dated 10/1/15 thru 10/30/15, indicated the resident had no behaviors. The "Orders" section of the chart and the Nursing Notes indicated the resident had not been monitored for the side effects of the hypnotic or any of her other medications. There was no indication a non-pharmalogical intervention had been attempted to induce sleep prior to administration of her medications. In addition, the residents response to the medications had not been documented. During an interview, on 10/30/15 at 10:10 A.M., the Social Service Director indicated the resident had not had any behaviors or symptoms of insomnia or depression. She could not explain what behaviors were being monitored on the behavior monitoring forms and indicated it was for any behaviors. She further indicated she completed the depression assessment quarterly in the MDS for the resident. The Social Service Director further indicated she would review nurses			

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	notes regarding the resident's insomnia and use of a hypnotic but could not recall having seen any nursing notes which indicated the resident had trouble sleeping. On 10/30/15 at 3:00 P.M., an interview was conducted with the Director of Nursing (DON) and the MDS Coordinator. The DON and MDS Coordinator both indicated care plans were developed by the Interdisciplinary Team. They could not explain why there were no care plans developed for Resident #4 regarding her medical concerns and/or medications. The DON indicated monitoring of medication side effects would be located under the "orders" section and nursing notes. On 11/2/15 at 11:42 P.M., the DON provided a policy titled " Monitoring," undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Policy: It is the policy of this facility to monitor all residents using psychopharmacological medications to evaluate the ongoing benefits as well as risks of various medications... Provisions...Effective monitoring relies upon understanding the indications and goals for using the medication, identifying relevant baseline information, identifying the criteria for			

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	evaluating the benefit of the medication and recognizing and evaluating adverse consequences... Procedures...ongoing monitoring shall include: a. completion of the Mood/Behavior Report Sheets and/or Mood/Behavior Tracking Log...." 5. On 10/30/15 at 9:19 A.M., record review indicated, Resident #20 was admitted to the facility on 7/15/15, with diagnoses included, but were not limited to, "...Parkinson's disease, restless leg syndrome, Alzheimer's disease, insomnia and delirium...." The admission MDS (Minimum Data Set) assessment, completed on 7/25/15, indicated Resident #20 was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 3. The behaviors assessment indicated the resident was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. The Nursing Admission/Re-Admit Observation Assessment, dated 7/15/15, indicated no Behavior/Mood. A Behavior Log, for July 2015, indicated the following: *On 7/22/15 at 3:50 A.M., rejection of care during toileting.			

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	*On 7/26/15 at 1:59 P.M., wandering. *On 7/30/15 at 11:53 P.M. resident pushing during toileting. A nursing progress note, dated 7/21/15, indicated "...resident continues to attempt to stand and ambulate without assistance throughout shift...." A physician order, dated 7/21/15, indicated Quetiapine (an antipsychotic) 50 mg (milligram) by mouth two times a day related to delirium. A nursing progress note, dated 7/22/15 at 9:17 A.M., indicated "...residents son tells writer that resident has been on antibiotics for prevention and treatment of frequent UTI's [urinary tract infection] and recommends the facility call the [physician name] to get prescriptions of rotating antibiotics...Son says resident gets more active when she gets a UTI and believes resident has a UTI now...." A nursing progress note, dated 7/22/15 at 11:55 A.M., indicated "...writer called [physician name] and reported sons concern of increased restless and increased urination and sons concern of UTI present. [physician name] ordered ua c&s [urinalysis with a culture and sensitivity]. Urine collected...[physician name] ordered if positive results of ua			

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	that resident is to increase dosage of Macrobid [antibiotic given for infection] to 100 mg bid [twice daily] for 5 days then return to normal dose of 100 mg every day...." A nursing progress note, dated 7/29/15 at 9:51 A.M., indicated "...resident has been restless this shift, attempting to stand and ambulate without staff assistance multiple times...." A nursing progress note, dated 7/30/15 at 11:47 P.M., indicated "...resident being very combative and would not accept help when transferring to the restroom or to the bed. Will continue to monitor...." A nursing progress note, dated 7/31/15, indicated "...behavior noted for frequently attempting to stand and ambulate without staff assistance...." A Behavior Log, for August 2015, indicated the following: *On 8/9/15 at 1:59 P.M., wandering. *On 8/12/15 at 1:14 P.M., wandering. *On 8/13/15 at 1:46 P.M., resident kicking/hitting. *On 8/18/15 at 12:49 A.M., rejection of care during toileting. *On 8/19/15 at 1:14 A.M., rejection of care during toileting. *On 8/19/15 at 10:12 A.M., wandering.			

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	*On 8/21/15 at 10:24 A.M., resident kicking/hitting during toileting. *On 8/21/15 at 9:59 P.M., resident yelling/screaming. *On 8/23/15 at 10:25 A.M., resident kicking/hitting during personal hygiene. *On 8/24/15 at 4:50 A.M., rejection of care during toileting. *On 8/30/15 at 3:41 P.M., resident kicking/hitting. *On 8/31/15 at 12:34 A.M., rejection of care during toileting. A Behavior Log, for September 2015, indicated the following: *On 9/4/15 at 9:24 P.M., threatening behavior. *On 9/30/15 at 10:24 A.M., resident kicking/hitting during toileting. A behavior Log, for October 2015, indicated the following: *On 10/9/15 at 11:03 A.M., resident biting during toileting. *On 10/18/15 at 10:33 A.M., kicking/hitting during personal hygiene *On 10/29/15 at 3:52 A.M., pinching/scratching/spitting during toileting A nursing progress note, dated 10/10/15, indicated "...resident is pleasant and sitting in lounge with others...Whenever resident is restless, she usually needs to			

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	be toileted...." The quarterly MDS assessment, completed on 10/2515, indicated Resident #20 was not exhibiting hallucinations or delusions, and the resident was not having physical or verbal behaviors towards others. A Note to Attending Physician/Prescriber, dated 10/29/15, indicated this resident is receiving Seroquel (an antipsychotic) 50 mg every morning and 50 mg every evening for Delirium due to physiological condition. Please consider dose reduction to Seroquel 25 mg twice a day. A physician order, dated 10/29/15 at 6:11 P.M., indicated Seroquel 25 mg by mouth two times a day related to delirium. On 10/29/15 at 9:28 A.M., Resident #20 was seated in a chair in the activity room on the dementia unit attending an activity, she was calm no behaviors observed. At 10:57 A.M., the resident was ambulated with the assist of 1 staff member to the television lounge, the resident was not resistant or combative, no delusional behaviors observed. At 11:40 A.M., the resident's son came into visit her and ambulated her to the dining			

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	room, she was quiet and calm. At 2:39 P.M., the resident was seated in a chair in the lounge with other residents eating a cupcake. No behaviors observed. During an interview, on 10/30/15 at 9:01 A.M., LPN #13 indicated Resident #20 gets agitated at times when the staff try to provide care. She indicated the resident frequently gets up out of her chair unassisted but redirection usually helps. She further indicated the resident has never had delusions. On 10/30/15 at 9:15 A.M., Resident #20 is awake and alert sitting in a chair in the activity room. At 10:45 A.M., a CNA was ambulating the resident in the hallway, the resident became resistant like she was trying to sit down in the hallway, at that time her son came to visit and assisted the resident into her room, she was placed in her recliner and resting quietly. At 1:30 P.M., the resident was resting quietly in her bed. At 2:45 P.M., the resident's bed alarm was alarming, a CNA entered the room to find the resident standing in the middle of the room unattended. The CNA assisted the resident into the lounge where she was resting quietly in a chair. On 10/30/15 at 9:37 A.M., review of a care plan, initiated on 7/21/15, indicated			

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	the focus: (resident name) uses antipsychotic/antidepressant medications r/t (related to) Alzheimer's disease and depression. Interventions included but were not limited to "...Administer medications as ordered. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Monitor for adverse effects every shift, notify MD as needed...." There was no other care plan related to target behaviors or monitoring of behaviors for Resident #20. During an interview, on 11/2/15 at 8:54 A.M., the Director of Nursing indicated Resident #20 was not receiving any psych services, per family physician orders. And the resident's physician also adjusts her medications as needed. During an interview, on 11/2/15 at 8:57 A.M., the Social Service Director indicated Resident #20 does not have any verbal aggression, she has had some recent physical aggression and some restlessness but she does not consider aggression/restlessness a behavior. She further indicated the nursing staff keep repeatedly charting the resident is having a behavior when she gets up out of the chair unattended. The Social Service Director indicated the resident does not have any delusions and no behavior care			

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	plans were developed because she does not exhibit anything that she would consider a behavior. On 11/2/15 at 11:42 A.M., review of the undated current policy titled "Monitoring" received from the Director of Nursing indicated "...Section 4.02 Provisions: The key objectives for monitoring the use of psychopharmacological medications are to track progress towards the therapeutic goals and to detect the emergence or presence of any adverse consequences. Effective monitoring relies upon understanding the indications and goals for using the medication...." 6. The clinical record for Resident #80 was conducted on 11/01/2015 at 11:09 A.M. A nurse's note, dated 9/30/2015 at 7:54 P.M., indicated Resident #80 had been "...overly loud and unable to redirect with food and conversation. Continues to bang on table and yelling out. Gave haldol 1ml [milliter] for increased agitation...." A nurse's noted, dated 10/4/2015 at 12:36 A.M., indicated that Resident #80 "...had a brief period of yelling out and attempting to climb oob [out of bed]. Resident assisted up in w/c and sat in MDR for about 30 minutes. Resident assisted back to bed and is resting quietly			

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	at this time...." A behavior report, dated 10/5/2015 at 1:41 A.M., indicated that Resident #80 had "...repeats movement...." as a behavior symptom. A nurse's note, dated 10/5/2015 at 3:03 A.M., indicated Resident #80 "...has been restless and anxious this shift. Resident has climbed out of bed greater than 7 times and refused to sit in wheelchair. After interventions of 1:1, toileting, and snack and repositioning for comfort Haldol injection was given in RUOQ [right upper outer quadrant]. Resident is resting quietly at this time...." On 10/7/2015 03:13 A.M., nurses note dated 10/7/2015 at 3:13 A.M., indicated that Resident #80 had "...stayed up until 12am. Staff offered assistance to bed x4 before that but resident was not ready for bed. No yelling out, pleasant and cooperative, offered and accepted thin liquids/flow control, resident had no problems with swallowing...." A behavior report, dated 10/12/2015 at 5:59 P.M., indicated Resident #80 was experiencing "...yelling/screaming....". The behavior report indicated that the staff used an intervention of offering "snack/beverage...." and the intervention			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was effective. During an interview on 10/30/2015 at 10:00 A.M., the Social Service Director indicated that a resident should not be given an antipsychotic medication unless the resident is experiencing behaviors that could harm themselves or someone else. 3.1-48(a)(6)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation and record review, the facility failed to ensure a medication error of less than 5 percent (%) for 2 of 7 residents observed during a medication pass. Two medication errors were observed during 29 opportunities for error in medication administration. This resulted in a medication error rate of 6.89 %. The errors involved 2 residents. (Resident #49 and Resident #34) Findings include: 1. On 10/29/15 at 8:07 A.M., Resident #49 was observed being administered her	F 0332	**F 332** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken**	12/04/2015

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	medications by RN #1. RN #1 had Resident #49 inhale her inhalation medication called Advair. The resident was given water from RN #1 with no instruction to rinse her mouth. RN #1 was observed walking out of the room and the resident was observed swallowing the water. The physician's order indicated the resident was to rinse her mouth, with water, after use of the inhaler Advair and not swallow the water. On 10/30/15 at 10:45 A.M., the Director of Nursing provided a manufacture's recommendation for the "Dosage and Administration" of Advair. The recommendations indicated "...After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis...." 2. On 10/30/2015 at 7:17 A.M., Resident #34 was administered 12 units of Humalog insulin subcutaneously by LPN #57. Resident #34 remained in her room and was not served any drinks or food until 7:52 A.M. when she was served her breakfast tray in her room. During an interview, on 10/30/15 at 7:55 A.M., with Resident #34, indicated she had not eaten or drank any beverages		**for those residentsidentified:** Resident #49, displays no symptomsoropharyngeal candidiasis. Resident #34, displayed no symptoms ofhypoglycemia on 10/30/15 **2. How the facility identified other resident:** All residents receiving steroid inhalers havethe potential to be affected. All residents receiving short actinginsulin and oral diet have the potential to be affected. **3.Measuresput into place/systems changes:** Licensed Staff were re-educated regardingrinsing of mouth after use of steroid inhalers and timing of short-acting insulinadministration within 15 minutes prior to meal or immediately after meal. Steroid inhaler orders will be updated toinclude instruction to rinse mouth after use. **4.Howthe corrective actions will be monitored:** The Director of Nursing/Designee willobserve medication administration pass for at least 3 residents per week x30days on varied different shifts to ensure medications are administered asordered according to manufacturer recommendations.	

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	since receiving her insulin shot. She indicated she did not feel lightheaded or bad. Review of the Internet site, from Lilly.com regarding the manufacturer's instructions for Humalog insulin indicated: "Administer the dose of Humalog within 15 minutes before a meal or immediately after a meal...." 3.1-48(c)(1) 3.1-25(b)(9)		These observations willinclude at least 1 resident receiving short acting insulin and/or steroidinhaler per week x30 days. Medicationpass observations will then be completed on at least 1 resident per week onvaried shifts thereafter until 100% compliance is achieved x3 consecutivemonths. The results of these auditswill be reviewed in Quality Assurance meeting monthly until 100% compliance isachieved x3 consecutive months. **1. Date of compliance: 12-4-15**	
F 0353 SS=F Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.			

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	Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review and interviews, the facility failed to ensure there was sufficient staff on 3 of 3 nursing units to provide adequate supervision of residents and/or to meet the needs of the residents regarding bathing and toileting. In addition, the facility failed to ensure staff working were knowledgeable regarding the care needs of the residents to whom they were assigned to provide care. This deficient practice potentially affected 52 of 52 residents residing in the building. Finding includes: 1. Interviews, conducted on 10/26/15 and 10/27/15, with 12 alert and oriented residents, revealed 8 of the 12 residents indicated there were not enough staff to answer call lights timely, give showers and/or baths as scheduled, and provide toileting if needed in a timely manner. In addition, 1 of 3 family members interviewed, on 10/26/15 to 10/27/15, also indicated they felt there was not enough staff to provide care in the building.	F 0353	**F 353** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** No corrective action could be taken forconcerns identified prior to survey. The facility disputes statements by staffand family members as documented in the 2567 regarding insufficient CNAstaffing to provide care, no licensed staff being assigned on the main hall oronly one nurse working in the building. This information is false and can be disputed by nursing staff timerecords. The facility does request that nursing managers and nursing staff workadditional shifts or overtime	12/04/2015

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	During an interview with two alert and oriented residents, who wished to remain anonymous, on 10/27/15 at 11:40 A.M., both residents indicated they had not been given their scheduled showers on a routine basis. One of the residents indicated, although he/she had received a shower in the past week, she had went almost a whole month without a shower. He/she indicated the staff had either not offered the shower to her/him or had informed them they were too busy and too short of staff to provide the shower. 2. Observation of the staffing as worked for 10/26/15 through 10/30/15 and the census and resident care needs for the Touchtone secured dementia unit indicated the following: There were 14 residents residing on the unit, 13 of whom had a dementia diagnosis and 5 of whom had behaviors. All 14 required one to two staff to assist them with bathing, dressing, transferring, toileting use and eating needs. Seven of the 14 were incontinent of their bladder and 5 were incontinent of their bowels. Four residents were in a wheelchair and 9 were independently ambulatory. The staffing schedule, which was supposed to be the schedule as worked, indicated on all 5 days, on the night shift, there was only one staff member assigned		to assist in covering shifts when staff memberscall off or open shifts are not covered so that adequate supervision and carecan be provided. **2. How the facility identified other residentspotentially affected:** All residents requiring assistance withactivities of daily living have been identified. **3.Measuresput into place/systems changes:** The nursing staff have been re-educated onexpectations regarding provision of careand supervision, including completion of bathing/showers as assigned and providingincontinence care. Staffing ratios have been reviewed andadjusted as indicated to ensure sufficient staffing to provide care. Anadditional staff member will be hired and assigned to work the midnight shifton the secured dementia unit, The new employee orientation will berevised to include use of the Kardex for assignments and a password for theelectronic charting system will be issued before the 1st day of orientationon the floor. New nursing staff will be assigned to all 3 units during theorientation	

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	to work on the secured dementia unit. During an interview, conducted on 10/30/15 at 6:20 A.M., with the only night shift staff for the unit, CNA (Certified Nursing Assistant) #67 indicated she had worked by herself on the unit during the night shift. She indicated most of the residents usually slept during her shift. When queried as to how she would supervise the whereabouts and activities of residents as they wandered if she was in a room providing care, she just shrugged her shoulders. CNA #67 indicated this was the usual staffing for the dementia unit. She indicated sometimes there was just one licensed nurse working on the 3rd shift instead of a nursing assistant. During the survey, Resident #89 was noted to have been incontinent on more than one occasion and he was not toileted and staff working seemed unaware of his need to be assisted to the toilet. 3. Observation of the staffing as worked for 10/26/15 through 10/30/15 for the main unit and the staffing schedule as worked indicated the following: There were 21 residents on the main unit, 9 with dementia, 6 requiring mechanical lift transfers, all 21 required assistance		process under the supervision of another employee. **4.Howthe corrective actions will be monitored:** The Director of Nursing or designee willinterview at least 3 residents per week to determine resident satisfaction withcare received. The Human Resources Director or designeewill interview at least 3 nursing staff employees on varied shifts to ensurestaff feel that they are provided adequate training and support to provideresident care. New nursing staffemployees will be interviewed prior to end of orientation to ensure that staffhas received adequate training. The Director of Nursing or designee willreview staffing levels at least 5x/week to ensure staffing is sufficient toprovide adequate supervision and/or meet resident care needs. The Director of Nursing ordesignee will audit 10 resident bathing records per week on varied units andshifts to ensure bathing is provided according to preference and care plan x30days, then 5 bathing records per week on varied units and shifts until 100%compliance is achieved x3 consecutive months. **1. Date of compliance:**	

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	for bathing, all 21 required assistance for dressing, transferring, toilet use, and eating needs. One resident needed completely fed. Three were bedfast, 12 were in wheelchairs and 4 were independently ambulatory. Thirteen were incontinent of urine and 10 were incontinent of their bowels. The staffing as worked schedule indicated there was one licensed nurse and two nursing assistants per shift working on 4 of the 5 days reviewed. On 10/26/15, there was no licensed staff member for the main unit. Three of the 4 days had day shift staff working over for part of the shifts and night shift coming in early to cover the rest of the shift. During an interview, conducted on 11/02/2015 at 2:45 P.M., a family member when he had visited on weekends there were a few Saturdays when there was no nurse in the building. In addition, he indicated often on Saturdays, there was only one nurse working in the building who seemed overworked and overwhelmed to him. He indicated the staff working tried but just could not get everything completed. The family member indicated his father resided on the Main unit. The shower schedules for the Main unit		**12-4-15**	

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	were reviewed on 10/30/15. The two anonymous residents, who were scheduled twice a week in the evenings to receive showers, were documented as either "Refused" or "Bed Bath" for the bathing documentation for both residents several times in the last month. Interview, on 11/02/15 at 2:00 P.M. with both residents indicated they had never received or been offered a bed bath instead of their shower and they absolutely would not refuse an opportunity to receive a shower. Both residents indicated they would not have preferred a bed bath but desired a shower. On 10/27/15 at approximately 4:55 P.M., two unidentified nursing staff, working on the Main unit, were overheard conversing about their work. One of the staff members was heard telling the other staff member they did not have time to get anyone out of bed or give showers on their shift due to not enough staff. During an interview, on 10/30/15 at 10:20 A.M., with Resident #68, who resides on the Main nursing unit, she indicated she had never received a bed bath and had never refused a shower. The resident further indicated CNA #5 and other aides (couldn't recall their names) had told her the bath tub was broken. Resident #68 indicated she had			

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	not received had a shower in the past week and she complained her hair was dirty. The resident indicated the aides tell her they do not have time. The resident's hair was observed to look oily and greasy . During an interview, on 11/2/15 at 830 A.M., CNA #7 indicated the shower list for the resident's was in the nursing station. She was observed looking at the bathing sheet and looking for Resident #68's bathing day and indicated she should have received a shower yesterday. During an interview, on 11/2/15 at 8:40 A.M., the Director of Nursing indicated the Nurse Aide bathing sheet recorded the resident as receiving a bed bath on 10/31/15 (Saturday). During an interview, on 11/2/15 at 8:45 A.M., the resident indicated she did not receive a bed bath or a shower Sunday (yesterday) or Saturday. Resident #68's hair still had not been washed and still looked oily. During an interview, on 11/2/15 at 4:00 P.M., CNA #8 indicated she had given Resident #68 a bed bath on Saturday evening. She indicated she had provided peri care and washed the resident's face and hands. CNA #8 further indicated she			

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	had not washed the resident's hair and indicated she had not given the resident a shower because she did not have time to complete a shower for the resident. She indicated she was aware the resident preferred a shower and her bathing days were Sunday and Wednesday, however she was doing the best she could give the current lack of staffing. 4. Observation of the staffing fro 10/26/15 through 10/30/15 and the staffing as worked schedule, and the resident census and needs for the West unit indicated the following: There were 20 residents on the unit, all of whom required staff assistance for bathing, dressing, transferring, toilet use, and eating needs. One of 20 needed fed. Four of 20 required mechanical lift transfers. Sixteen were incontinent of urine and 7 were incontinent of their bowels. Eight had dementia and 2 had behavior care needs. Twenty one were in a wheelchair and 4 were independently ambulatory. On 10/26/15 and 10/27/15, Resident #41 was observed seated in the dining room without being toileted. On 10/29/15 and 10/30/15, the Resident #41 was not toileted per her care plan. She was only provided incontinence care but was not			

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	toileted. During an interview on 10/30/15 at 6:19 A.M., RN (Registered Nurse) #68 indicated she had worked on the West unit at times, especially on the weekends by herself. She indicated she could not get all of her work completed when she was the only staff member. She indicated in the past few weeks she had not had any weekends where she was the only staff member scheduled. In addition, on 10/30/15, CNA #50 and CNA #52 were observed to ambulate Resident #80 back to his room, lay him on his bed, a proceeded to prepare to change his incontinence brief. After discovering the brief was dry, the CNA's looked at each other and CNA #52 asked CNA #50 if the resident was supposed to be toileted. CNA #50 indicated she had seen a urinal in the bathroom so then they proceeded to attempt to toilet Resident #80 with the urinal. During an interview on 10/30/2015 at 9:24 A.M., CNA #50, who was working on West hall, indicated it was her second day on the job and she was not yet given a computer password for access the facility's electronic system, was not given any assignment sheet or guidelines with instructions for the residents she was			

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	responsible for taking care, and had oriented yesterday with a staff member but it was not on the West unit. CNA #50 indicated she was working on 10/30/15 with CNA #52. During an interview on 10/30/15 at 9:30 A.M.,CNA #50 indicated she had only worked at the facility for 4 days, did not yet have computer access, and had not been given any care instructions for the residents she was to take care of on the West unit. During an interview on 11/02/15 at 9:10 A.M., LPN #65, who was working on the West unit, she indicated she was had only worked at the facility for two weeks and was not sure what behaviors were to be monitored for Resident #90. LPN #65 attempted to look at the care plans for Resident #90 but did not know how to utilize the facility's electronic system to open the care plans so she could view them. During an interview with CNA #64, on 10/28/15 at 3:00 P.M., she indicated there was no specific information for Resident #90 in the Kardex (electronic charting system). CNA #64 indicated because she had taken care of Resident #90 since she was admitted to the facility, she knew the resident required a two person transfer			

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	On 10/29/15 at 10:45 A.M., CNA #53 was observed to transfer Resident #90 by herself from her wheelchair to her bed. The resident was noted to have extensive deep purple bruising on her left shoulder, back of her left thigh, and abdominal area. CNA #53 indicated she had only worked at the facility for two weeks and did not know where the bruising came from. She indicated she knew for a fact the resident had not fallen at the facility. CNA #53 indicated she did not have any specific instructions regarding the transfer needs or any care needs for Resident #90. 3.1-17(a)			
F 0356 SS=B Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.			

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	The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, record review and interviews, the facility failed to ensure the staff posting was accurate for 1 of 7 days of the survey, 10/26/15. This potentially affected all residents and visitors who might have observed the inaccurate posting. Finding includes: On 10/26/15 at 10:30 A.M., the daily staff posting, noted on the wall beside the Social Service office, indicated on the day shift 7 CNAs were working. Observation of staff on 10/26/15 at 10:30 A.M. - 11:00 A.M., indicated only 5 CNA 's were noted working. During an interview, on 11/04/15 at 3:20 A.M., the Director of Nursing (DON) indicated	F 0356	**F 356** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** No residents were identified asaffected. The posted staffing sheet wascorrected to reflect the accurate staffing worked for that specific shift.	12/04/2015

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	155702	A. BUILDING 00 B. WING	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	there were 5 CNAs assigned to the various nursing units and the other 2 CNAs were restorative aides. The DON indicated on 10/26/15 only one of the two restorative CNAs had worked so she had "fixed" the number from 7 to 6 sometime after it was observed at 10:30 A.M.		**2. How the facility identified other residentspotentially affected:** No residents were identified asaffected. Staffing sheets for the current week werereviewed for accuracy. **3.Measuresput into place/systems changes:** The Director of Nursing and nursingmanagers were re-educated on the procedure for completing and updating thestaff posting form with changes. **4.Howthe corrective actions will be monitored:** The Director of Nursing or designee willaudit the staffing sheet posted at least 5x/week to ensure that the staffingsheet is accurate and reflects any changes as indicated. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance:** **12-4-15**	
F 0364 SS=D Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and			

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	appearance; and food that is palatable, attractive, and at the proper temperature. Based on observations and interviews, the facility failed to serve Resident #80's breakfast at the proper temperature to 2 of 2 residents. (Resident #80 and #41) Finding includes: 1. On 10/29/15 at 8:00 A.M., breakfast was served in the West dining area. Two trays were left sitting on ledge in front of the serving area. On 10/29/15 at 8:31 A.M., Resident #80 was propelled to the dining room and placed in front of a table that had a tray on it. The tray had 3 containers under a large mauve lid Under the lid was 3 containers, with one container having an additional plastic sealed lid. The mauve lid was removed by a CNA as she prepared to feed the resident. The CNA was asked not to feed the resident until the temperature of the food items were checked, she placed the lid back over the food. On 10/29/15 at 8:35 A.M., the following items had a temperature check by Dietary Manager #2: -scrambled eggs - 82 degrees -pureed biscuits and gravy - 82 degrees -oatmeal with plastic sealed container	F 0364	**F 364 Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance. Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #80, a new tray was provided forthe breakfast meal. Resident #41, food was re-warmed beforeserving. **2. How the facility identified other resident:** All residents receiving an oral diet havethe potential to be affected. **3.Measuresput into place/systems changes:** Food temperature log sheet hasbeen reviewed and updated to reflect the appropriate temperature range for foodholding at point of service. The dietary staff were re-educated on properfood temperatures at point of service. **4. Howthe corrective actions will be monitored:** The Dietary manager or designee will perform temperature checks at point of service on at least 2	12/04/2015

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	removed - 104 degrees. During an interview, on 10/29/15 at 8:40 A.M., the Dietary Manager #2 indicated the food was too cold for the resident to be served. 2. On 10/29/15 at 12:00 P.M., Dietary Cook #9 was observed serving the noon meal from the West hall servery. Most of the food was transported on a covered cart and placed in pans on the steam table. However, there was a plastic tray with bowls of pureed food already dished up left in the covered cart. When Cook #9 went to serve Resident #41, the temperature of the food was requested. The pureed vegetables was 80 degrees, the pureed sweet and sour pork was 122 degrees and the rice was 124 degrees. Cook #9 then placed the food in the microwave about a minute. She then proceeded to place the bowls on a tray and started to send the food out to be served. Another temperature of the pureed food was requested and the pork was 116 degrees, the rice was 120 degrees and the vegetables were 94 degrees. She then put the food in the microwave for a second time and then the pork was 138 degrees, the rice was 142 degrees and the vegetables were 136 degrees.		resident trays 3x/ week at varied meals and meal locations to ensure food is served at the appropriate temperature. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **5. Date of compliance: 12/4/15**	

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	3.1-21(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interviews, the facility failed to ensure food was prepared and stored in a sanitary manner related to food storage and timely disposal of food, the use of unpasteurized eggs for soft and over easy eggs, cleanliness of the ice machine and convection oven. This had the potential to affect for 52 of 53 residents who consumed food. Finding includes: During the kitchen sanitation tour, conducted on 10/26/15 from 10:15 A.M. - 10:46 A.M., the following was noted: The only eggs observed in the walk in refrigerator were unpasteurized eggs.	F 0371	**F 371 Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance. Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** The unpasteurized eggs were removed fromthe facility. The left over ham and beans, hamburger,taco meat and the chunky tomato soup were	12/04/2015

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	During an interview with the FSS, during the tour, she indicated the facility served both soft fried and over easy eggs on a daily basis. The FSS indicated she was unaware the eggs needed to be pasteurized if served in that manner. In addition in the walk in refrigerator there were left over containers of ham and beans, dated 10/23/15, cooked hamburger dated 10/22/15, taco meat dated 10/22/15, and chunky tomato soup dated 10/13/15. During an interview with the FSS she indicated she knew the leftovers were to be discarded after 3 days but the facility had thought previously they could use leftovers up to 7 days old. She indicated the Registered Dietician had informed her of the proper 3 day time frame on 10/23/15. In the reach in refrigerator there were roast beef and cheddar sandwiches dated 10/23 and a tray of uncovered desserts and pudding. In addition, the top of the reach in refrigerator had a cooling fan/motor unit without a protective covering and coated with dust. Both convection ovens had a build up of light tan greasy substance on the outside and inside of the doors and there was burnt spilled food noted on the oven inside bottoms.		discarded. The roast beef and cheddar sandwiches,uncovered desserts and pudding were discarded. The cooling fan/motor unit on top of thereach-in refrigerator was cleaned. The convection ovens have been cleanedinside and outside. The inside edge of the ice machine hasbeen cleaned, the spider web has been removed and the drain tube under the icemachine has been repositioned. **2. How the facility identified other resident:** All residents' receiving and oral diethave the potential to be affected. **3.Measuresput into place/systems changes:** The dietary staff wasre-educated regarding cleaning schedules, food storage and disposal guidelines . Unpasteurized eggs will nolonger be ordered. Cleaning schedule log was implementedfor the ice machine, convection ovens, and cooling fans every 2 weeks. The walk in refrigerator willbe checked 3 days a week for outdated food and uncovered food. **1. How the corrective actions will be monitored:** The Dietary Manager will check the walk inrefrigerator 3 X week for uncovered and out dated foods and place findings onand audit tool. The Dietary Manager will check the convectionovens, ice machine and cooling fan/motor weekly and place findings on and audittool.	

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	The ice bin, located in the dining room beside the steam table had dark gray spots/black spots on the inside edge above the ice. There was also a spider web with a spider behind the ice machine. The ice machine drainage tube, coming from the bottom of the ice machine was touching another plastic tubing and the edge of the floor drain. During an observation of a breakfast service on the West hall, conducted on 10/30/15 at 7:15 A.M. , Dietary cook #61 was observed preparing soft fried and over easy eggs with non-pasteurized eggs. The FSS was notified of the issue and she went to the main kitchen, retrieved pasteurized eggs, and replaced the non-pasteurized eggs with pasteurized eggs. During an observation of the nourishment pantry's, conducted on 11/04/15 at 9:30 A.M., one container of cottage cheese with pineapple on top in a covered plastic container was observed in the refrigerator on the dementia unit. The container was dated 10/21/15 and the cottage cheese was looking yellowish. CNA #62 exclaimed "yuck that doesn't even look good" and threw the container away. 3.1-21(i)(2)		Theresults of these audits will be reviewed in Quality Assurance Meeting monthlyuntil 100% compliance is achieved x3 consecutive months. **1. Date of compliance:** 12/4/15	

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F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure 6 of 14 insulin vials and 6 of 6 IV start needles checked were within their expiration limits. In addition, the facility failed to ensure 2 of 3 multidose Mantoux vials were labeled with an open date and failed to	F 0425	**F 425** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the*	12/04/2015

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	ensure 1 of 3 mulitdose Mantoux vials, dated with an open date, was not expired. Findings include: During a medication storage observation on 11/02/2015 at 3:25 P.M., the following was observed: A Mantoux (Sanofi Pasteur Limited) vial was found to be undated and opened located in the refrigerator on the West Hall nurses station. An interview with employee #30 indicated there was no way to tell if the Mantoux vial was still safe for use due to no open date documented. In the Touchstone Unit 6 of 6 insyte auto guard (IV needle starts) observed were noted to be expired as of 06/2015. An interview with employee #3 indicated that the insytes were expired. In the Main Hall medication cart the following was observed: *Humalog insulin for Resident #30 was opened but not dated *Humalog insulin for Resident #24 was opened but not dated *Lantus insulin for Resident #45 was opened and dated 10/1 *Humalog insulin for Resident #45 was opened and date of 9/21 *Humalog insulin for Resident #45 was		*facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** The 6 expired insulin vials have beendisposed of and re-ordered. The 6 IV start needles have been removedfrom the inventory and disposed of. The non-dated and expired Mantoux vialshave been disposed of and re-ordered. **2. How the facility identified other resident:** Medication carts and medication rooms wereaudited for labeling of open date on opened vials, and expired medications andIV/sterile items. **3.Measuresput into place/systems changes:** Licensed staff have be re-educatedon initialing and dating of insulin and mantoux vials upon opening and disposalupon expiration. **1. How the corrective actions will be monitored:** The Director of Nursing or designee willaudit the medication room and medication cart 2 times a week for appropriatelabeling of	

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	opened and not dated *Humalog insulin for Resident #45 was opened and dated 9/20 In the refrigerator on the Main Hall Unit there was a Mantoux multiuse vial opened with no open date and a Mantoux multiuse vial with an open date of 10/1. Interview with employee #6 indicated that these insulin vials should be disposed of due to an expiration date that has passed or the inability to know if the vials were within their expiration date due to there not being an open date. On 11/4/2015 at 9:05 A.M., the Director of Nursing provided a policy titled "MEDICATION STORAGE, LABELING AND EXPIRATION DATES" and indicated "...4. Facility should ensure that medications and biologicals that: (1)have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record		date opened, expired meds and supplies. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance:** **12-4-15**	

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	the date pened on the medication container when the medication has a shortened expiration date once opened...." 3.1-25(k)(6)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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			

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	disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observations, interviews and record review the facility failed to clean and properly store nebulizer masks, tubing and medication dispensers for 2 of 2 residents observed to have nebulizer equipment. (Resident #88 & #39) B. Based on observations, and interview the facility failed to ensure 1 of 2 staff administering injectable medication transported a subcutaneous needle was transported properly on 1 of 3 nursing units. C. Based on observation, interview and record review the facility failed to ensure a glucometer was cleansed properly after its use for 1 of 2 residents who used the glucometer on the dementia unit. (Resident #33) Findings include: A.1. On 10/26/15 at 4:54 P.M., Resident #88's nebulizer mask and tubing lying in uncovered on top of the nebulizer	F 0441	**F 441** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** Resident #88 & #39- Nebulizermasks were cleaned placed in a plastic storage bag. Resident #33 shows no signs orsymptoms of infection at injection site. LPN #3 was educated on the useof protective shield to protect uncapped syringes during transport and procedurefor cleaning glucometers and wearing gloves during glucometer cleaning.	12/04/2015

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	machine. The mask had white debris on the interior side of the mask and there was liquid in the medication cup. A.2. On 10/29/15 at 11:35 A.M., Resident #39's nebulizer mask and medication cup was observed lying on top of a plastic zip lock bag. LPN (Licensed Practical Nurse) #4 indicated he wanted to cleanse the medication cup because it had liquid in it. LPN #4 indicated the mask and tubing and medication cup were changed weekly but there was no policy regarding cleansing the equipment after each use. On 11/4/15 at 1:50 P.M., the Director of Nursing (DON) provided a policy titled "Medications Nebulizer Therapy, dated 9/2005, and indicated the policy was the one currently used by the facility. The policy was the one currently used by the facility. The policy indicated "...15. Disassemble the nebulizer, mouthpiece and T-piece and clean according to the procedure and instructions from manufacturer. Wear gloves for cleansing of equipment. Pieces should be stored in a plastic bag with the resident's name and date equipment was issued...." During an interview, on 11/4/15 at 2:10 P.M., the DON indicated she would expect nurses to clean the nebulizer		**1. How the facility identified other residentspotentially affected:** All residents receivingnebulizer treatments have the potential to be affected. All residents receiving injectablemedication and receive blood sugar checks with glucometer have the potential tobe affected. **1.Measuresput into place/systems changes:** Licensed nurses were re-educated onstorage of nebulizer masks in plastic storage bags when not in use, cleaning ofnebulizer equipment after each use, use of protective shield to protect uncappedsyringes during transport and cleaning procedures for glucometers. Plastic storage bags will be provided forstorage of nebulizer masks and will be changed weekly with the change ofnebulizer equipment and PRN. Asecond glucometer will be placed on each medication cart to accommodateappropriate cleaning and drying time between each use. **2. How the corrective actions will be monitored:** The Director of Nursing or designee will conductobservation	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	equipment with mild soap and water, let it air dry and place equipment in a plastic bag after each use. B. On 10/29/15 at 7:34 A.M., LPN #3 was observed drawing up insulin for Resident #33. LPN #3 took the uncapped subcutaneous needle with the syringe, through the hallway, to the resident's room and then laid the syringe on an unopened alcohol wipe, on the bedside table prior to administrating the medication. On 1029/15 at 10:40 A.M., the DON indicated the syringe had a safety cap and it was inappropriate for a nurse to expose the syringe's needle when a safety cap would of covered the needle part of the syringe while being transported through the hallway, to the resident's room. C. During a medication administration observation, on 10/29/15 at 7:40 A.M., LPN #3 was observed cleaning a glucometer after testing Resident #33's blood sugar. LPN #3 used a PDI (Professional Disposables Internation) Sani Cloth Bleach Germicidal wipe to cleanse the glucometer, however she did not follow package instructions to leave the product on device for 4 minutes or use gloves.		rounds 3x/week on varied shifts to ensure nebulizer masks arebagged and clean. The Director of Nursing or designee will conductreturn demonstration audits on 3 nurses per week for glucometer cleaning andprocedure for safe transport of filled syringe. The results of these auditswill be reviewed in the Quality Assurance meeting monthly until 100% complianceis achieved x3 consecutive months. **1. Date of compliance: 12-4-15**	

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	155702	A. BUILDING 00 B. WING	11/04/2015

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	On 10/29/15 at 10:44 A.M., the Director of Nursing provided a policy titled, "Maintaining the Blood Glucose Meter," undated and indicated the polity was the one currently used by the facility. The policy indicated "...The blood glucose monitor should be cleaned and disinfected between each resident test...." A glucometer manual was received from the Director of Nursing on 10/29/15 at 10:45 A.M., and indicated the manual was for the glucometers currently used in the facility. Page 47 of the manual indicated "...Cleaning & Disinfecting Guidelines: Healthcare professional should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood present a potential infection risk. We suggest cleaning and disinfecting meter between patient use...Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide...To use a wipe, remove from container and follow product label instructions to disinfect the meter...." Another form regarding the cleaning and disinfecting of the Assure Platinum Blood Glucose Meter indicated PDI Sani-cloth Bleach Germicidal Disposable Wipes could be used to disinfect the meter.			

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	The PDI Sani-Cloth Bleach Germicidal Wipe box indicated "...a four (4) minute wet contact time must be used...." 3.1-18(a)			
F 0456 SS=E Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review and interview, the facility failed to ensure the dishwashing machine was functioning properly in 1 of 1 kitchens. This affected 2 of 3 nursing units who were served on disposable tableware and silverware for a month. Finding includes: During the kitchen sanitation tour, conducted on 10/26/15 from 10:15 A.M. to 10:46 A.M., the dishwasher was noted to not be working. During an interview with the FSS she indicated the dishwasher was broken and not able to be fixed. She indicated the facility was supposed to get a replacement dishwasher installed she hoped this week sometime. She indicated the machine	F 0456	**F 456** **Thefacility requests paper compliance for this citation.** *ThisPlan of Correction is the center's credible allegation of compliance.* *Preparationand/or execution of this plan of correction does not constitute admission oragreement by the provider of the truth of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.* **1. Immediate actions taken for those residentsidentified:** The Dishwasher was installed andoperational on 11/4/15 the residents' were served on regular dinnerwarestarting at breakfast on 11/5/15.	12/04/2015

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	had been broken for about the past 2 weeks. She indicated while it was down, the staff were serving most of the resident on paper and/or Styrofoam plates, cups and bowls and plastic disposable silverware. She indicated the dementia unit was still being served with tableware which was washed by hand in a 3 compartment sink. During an interview, on 10/30/15 at 7:30 A.M., the administrator indicated the new dishwasher was to be delivered and installed next week. She indicated the machine was already broken when she started working at the facility. During the breakfast meal observation, conducted on 10/30/15 from 7:15 A.M. to 8:30 A.M., Resident #27 indicated he was sick and tired of being served meals on paper and/or Styrofoam plates. He indicated the dishwasher had been broken for about a month. He indicated the other day staff were attempting to serve him his lunch meal and the paper plate bent with food on it and dumped the food all over the table and floor. Emails from the Maintenance Supervisor, Employee #63, indicated the dishwashing machine had stopped working sometime on the weekend of Oct 3 -4, 2015. A repairman had been out and accessed the		**2. How the facility identified other resident:** All residents receiving an oral diet onthe West Hall and Main Hall had the potential to be affected. **3.Measuresput into place/systems changes:** A monthly preventativemaintenance schedule has been set up for the dishwasher with an outside venderto ensure proper functioning. **1. How the corrective actions will be monitored:** The Maintenance Director or designee willkeep a log of all equipment needing repair and record the date equipment isrepaired or replaced. The Administrator or designee will review log weekly toensure equipment is repaired or replaced in a timely manner. The results ofthese audits will be reviewed in Quality Assurance Meeting monthly until 100%compliance is achieved x3 consecutive months. **2. Date of compliance:12/4/15**	

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	repair estimates were sent to the corporate staff. Review of the emails from Corporate staff, the service company and the Employee #63 indicated from 10/06/15 to 10/15/15, the corporate staff had decided to lease a dishwashing machine from the service provider. The email on 10/15/15 indicated the corporate legal staff wanted the standard lease agreement from the service provider amended. During an interview with Employee #63, conducted on 11/04/15 at 9:20 A.M., he indicated there was a delay in obtaining the dishwasher because the corporate staff wanted the lease agreement changed and then would wait a few days to respond to email requests and then there were also delays because files sent for the agreement could not be "opened" by both parties due to computer issues and had to be resent. He indicated the dishwashing machine was delivered to the facility on 10/30/15, and was supposed to have been installed on 11/03/15, but the service provider responsible for the installation had "double booked" the installers and the dish machine was supposed to be installed today. There was no reasonable explanation as to why, when a decision to lease a new dishwashing machine had been made on			

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	10/06/15, there had been a 3 week delay in obtaining a new machine. 3.1-19(bb)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interviews and record review, the facility failed to provide a safe and clean resident environment related to, undated Intravenous (IV) fluid and tubing in a resident room, holes in the walls of resident restrooms, a stained privacy curtain, paint in poor repair on doors, around door trim and walls, peeling paint on a restroom floor and a bed control that was not functioning properly. This had the potential to affect 5 of 20 residents residing on the South hallway, 7 of 20 residents residing on the West hallway, and 14 of 14 residents residing on the Touchstone dementia unit. Findings include:	F 0465	**F 465 The facility requests paper compliancefor this citation.** *This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.* **1) Immediate actions taken for thoseresidents identified:** Room 401- Holes in the bathroom walls havebeen repaired and bag of adult briefs and resident shirt was removed frombathroom floor. Room 409- Holes in bathroom wall have	12/04/2015

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	On 11/2/15 from 10:45 A.M. to 11:45 A.M., an environmental tour was conducted with the Maintenance Director and the Housekeeping Supervisor, during which the following was observed: 1. West Hallway: At 10:45 A.M., Room 408, the bathroom walls were observed to have 16 separate holes the size of a pencil eraser. During an interview, on 11/2/15 at 10:45 A.M., the Maintenance Director indicated the previous occupants of Room 408 had several towel racks mounted on the restroom walls. The current resident residing in the room was using the towel racks as grab bars, so the staff decided the towel racks should be removed due to safety issues and the holes in the walls had not been repaired. At 10:47 A.M., Room 409, the bathroom walls were observed to have multiple holes the size of a pencil eraser. During an interview, on 11/2/15 at 10:47 A.M., the Maintenance Director indicated the same issue occurred as the previous room, several towel racks were mounted on the walls and were removed due to safety issues and the holes had not been repaired.		beenrepaired. Room 403- Privacy curtain has been takendown and laundered. Room133- Bed control has been replaced and is operating fully. Room 117&137- Scrapes and gouges onthe bathroom door and door frames have been repairedand paint touched up. Room 118- Urinal, IV tubing and IV solutionwere removed. Room200- Peeling paint has been removed from tiles under the toilet and 2 walls and were re-painted. SouthHall central bathroom has been cleaned and paint touched up around door anddoor frame. **2) How the facility identified otherresidents:** Auditwill be completed of resident rooms to identify any other environmentalconcerns. **3) Measures put into place/ Systemchanges:** Staffhave been educated regarding process for completing work order and placing inmaintenance mailbox when equipment are in need of repairs Thehousekeeping staff have been re-educated on checking privacy curtains whencompleting general housekeeping duties and to remove if soiled. Nursingstaff will be re-educated regarding dating of IV solution bags and tubing. Maintenancedirector or designee will check all beds to ensure proper functioning. **4) How thecorrective actions will be monitored:**	

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	At 10:56 A.M., Room 403, the privacy curtain for bed 1 was observed with a brown stain on it. During an interview, on 11/2/15 at 10:56 A.M., the Housekeeping Supervisor indicated the resident rooms are deep cleaned once a month and a checklist is used at that time which includes checking the privacy curtain. She further indicated if the curtains are stained or soiled between monthly deep cleaning her expectation would be for the housekeeper to clean the curtain. At 10:57 A.M., Room 401, the bathroom walls had 10 holes the size of a pencil eraser, a bag of adult briefs and a resident shirt was on the bathroom floor. 2. South Hallway: At 10:58 A.M., Room 133 bed 1, the bed controls were not functioning properly. The Maintenance Director attempted to demonstrate how the control works and the resident who was resting in the bed indicated "don't mess with it right now I am resting trust me they still don't work right." On 10/26/15 at 10:15 A.M., the resident residing in room 133 bed 1 indicated his bed controls had not been functioning properly for some time but		MaintenanceDirector will develop a log and schedule to complete inspection and repairs onat least 3 resident rooms or resident common areas per week until all arecompleted. Inspection of resident areaswill be completed at least semi-annually for routine maintenance and upkeepthereafter. The Director ofNursing or designee will conduct observation rounds at least 3x/week on varied shifts to ensure IV solutionbags and tubing are dated. The Environmental Supervisor will observe at least 5rooms per week to ensure privacy curtains are clean and in good condition. The results of these audits will be reviewed inQuality Assurance Meeting monthly until 100% compliance is achieved x3consecutive months. **5) Date of compliance: 12-4-15**	

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	could not recall for how long. The Resident demonstrated by pressing the head, foot and knee buttons on the bed control. When the resident pushed the button for the foot the mid section for the knees raised up. The resident indicated "I keep telling them about but they don't do anything, they tried to fix it once by switching bed controls with another bed but it didn't help, and they haven't done anything about it since." During an interview, on 11/2/15 at 10:59 A.M., the Maintenance Director indicated he had exchanged the bed controls with another bed, but apparently the controls are still not working right, he further indicated he would look into the problem. At 11:00 A.M., Room 137, scrapes and deep gouges were observed on the door frame surrounding the bathroom door. At 11:01 A.M., Room 117, scrapes in the paint were observed on the bathroom door and the door frame. At 11:05 A.M., Room 118, the resident was not observed in the room, a liter bag of 1/2 normal saline IV solution with tubing that had fluid in it was at the resident's bedside, neither the IV bag or tubing was dated. In the resident's bathroom a urinal with no lid was			

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	observed hanging on the back of the toilet. During an interview, on 11/2/15 at 11:05 A.M., the Housekeeping Supervisor indicated she was unsure why this particular resident had an uncovered urinal in the bathroom since the resident was a female. 3. Touchstone Dementia Unit: At 11:13 A.M., Room 200, the bathroom floor tile under the toilet and the tile on the 2 walls surrounding the toilet had dark green peeling paint observed. During an interview, on 11/2/15 at 11:13 A.M., the Housekeeping Supervisor indicated the previous resident in the room was having trouble finding the toilet so the therapy department decided to paint the walls and the floor around the toilet so it would help the resident identify the toilet. She further indicated the paint is in the grout and peeling off so it makes it hard to clean and she was unsure what to do with it. At 11:20 A.M., the Central bathroom located across from the nurse station, observed scrapes around the bathroom door and the door frame. The restroom also had a strong urine odor.			

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	During an interview, on 11/2/15 at 11:21 A.M., the Maintenance Director indicated when staff discover issues with equipment or in resident rooms they are to complete a work order and place it in his mailbox. When he or his assistant receive the work order they would prioritized the concern, according to the priority. During an interview, on 11/2/15 at 11:34 A.M., the Director of Nursing indicated the bag of IV solution and tubing that was observed in Room 118 should have been dated. 3.1-19(f)			
F 9999 Bldg. 00	3.1-34 SOCIAL SERVICES (d) In facilities of one hundred twenty (120) beds or less, a person who provides social services is an individual with one (1) of the following qualifications: (2) A bachelors' degree or advance degree, or both in social work or a degree in human service fields, including, but not limited to:	F 9999	**F9999** **The facility requests paper compliancefor this citation.** *This Plan of Correction isthe center's credible allegation of compliance.* *Preparation and/or execution of this*	12/04/2015

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	(A) sociology; (B) special education; (C) rehabilitation counseling; (D) psychology; and (E) gerontology; and one (1) year of supervised social service experience under the supervision of a qualified social worker in a health care setting working directly with individuals. This State rule was not met as evidenced by: Based on record review and interview the facility failed to hire a Social Service Director with experience in a health care setting and the facility failed to provide orientation/supervision in a timely manner for the Social Service Director. Finding includes: On 11/4/15 at 9:10 A.M., a Social Service Orientation Checklist was received from the Administrator regarding the Social Service Director. The form indicated the Social Service Director had signed her own initials on each section as completed. During an interview on 11/4/15, the Social Service Director indicated she graduated in May of 2015 with a		*plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.* **1) Immediate actions taken for thoseresidents identified:** Noresidents were identified as being affected. SocialService Director did receive appropriate orientation and training by SocialService Directors at 2 other sister facilities on several occasions upon hireand Social Service Consultant firm. The Social Services Director is also theappointed Dementia Program Director in this facility. **2) How the facility identified otherresidents:** No residents were affected. **3) Measures put into place/ Systemchanges:** Thefacility employs an outside contracted Social Services Consultant firm to provide training and oversight ofrequired job functions every 60 days and as needed.	

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	bachelor's degree in Sociology and was hired on 6/22/15, with a start date of 6/22/15. She indicated she had completed a 6 month internship in a long term care setting but had only been responsible for completing BIMS (Brief Interviews for Mental Status) assessments and the Mood sections of the MDS (Minimum Data Set) assessments. She began her orientation to her role as the Social Service Director, two months later, on 8/20/15, with a local consult company for Social Services. The consult company returned on 9/24/15 to complete the orientation. The Social Service Director further indicated she was the only social worker in the building. 3.1-34(d)(2) 3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility within the past		Anew Social Services Director has been appointed to also serve as the DementiaProgram Director. 12 hours ofdementia-specific training will be completed within 90 days of hire date. **4) How thecorrective actions will be monitored:** The Social Service Consultant will complete auditsand consultation reports at least every 60 days. The Administrator or designee will ensure anappropriate Dementia Program Director is in place on an ongoing basis. The results of these audits will be reviewed inQuality Assurance Meeting monthly for a total of 6 months. **5) Date of compliance: 12-4-15**	

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	five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both of cognitively impaired resident; (2) gain understanding of the current standards of care of care for residents with dementia. This State rule was not met as evidenced by: Based on observation and interview the facility failed to employ a dementia director, for their secured dementia unit. Finding includes: During the initial tour on 10/26/15 at 10:45 A.M., a secure dementia unit was observed with 14 residents residing on the unit. During an interview, on 11/4/15 at 11:45 A.M., the Administrator indicated she			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had just started working in the facility approximately 3-4 weeks ago and had not hired a Touchstone Dementia Unit Director to date. 3.1-34(w)			