STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey-Immediate Jeopardy. Survey dates: June 20, 21, 22, 23, 24, and 25, 2016. Extended Survey dates: June 26, 27, 28, and 29, 2016 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census bed type: SNF/NF: 31 Total: 31 Census payor type: Medicare: 6 Medicaid: 24 Other: 1 Total: 31 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/30/16 by	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.	

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

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F 0323 SS=J Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and interventions to prevent a resident identified at risk for falls from falling 9 times in 10 months resulting in a fractured left humerus (long bone of arm), fractured left greater trochanter (hip), fractured right hip, fractured left wrist and a laceration to the forehead for 1 of 3 residents reviewed for accidents (Resident #8). The Immediate Jeopardy was identified on 6/23/16 and began on 9/3/15 when Resident #8 had an unwitnessed fall resulting in a fractured left humerus and the facility failed to implement interventions to prevent the resident from falling 7 additional times resulting in additional broken bones and lacerations. The Administrator, Director of Nursing (DON), and Nurse Consultant were informed of the Immediate Jeopardy on 6/23/16 at 1:15 p.m.	F 0323	F323 Requires the facility to ensure adequate supervision and interventions to prevent a resident identified at risk for falls from falling. RE: Resident #8 One on one monitoring has continued times four days. Staff assigned are specifically monitoring the resident's actions/behaviors, in an effort to determine best interventions following the cessation of one on one monitoring in an effort to prevent further falls. The resident has made no attempts to transfer or ambulate independently during the observation period. The resident did make verbal requests daily after breakfast to toilet. As a result of the observations, supervision will be reduced from one on one to every fifteen minute checks. Moving forward, the facility has purchased a visual and audible baby monitor. Should the fifteen minute checks reveal a continued pattern of calmness, the checks will be discontinued, and the nurse on duty shall be responsible to carry	07/13/2016

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	Finding includes: During an interview on 6/21/16 at 3:00 p.m., Resident #8's family member Resident #8 had multiple falls with fractures and injuries and was afraid the resident would not survive if she sustained another fall. On 6/21/16 at 1:30 p.m., Resident #8 was observed lying in bed, positioned on her back. Quarter side rails were raised on both sides of the bed. Resident #8 was unable to locate or push her call light when requested. On 6/21/16 at 2:40 p.m., Resident #8 was observed to be sitting on side of bed with feet touching landing mat next to bed. The resident was attempting to get of bed to go to the bathroom. Staff was present in room at this time. The resident continued to attempt to get out of bed even when staff was directed resident to wait for assistance. On 6/23/16 at 9:50 a.m., Resident #8 was lying in bed, positioned on her back on a low air loss mattress. Quarter side rails were raised on both sides of the bed. A brown floor mat was placed 10 inches away from the edge of the bed on a lighter brown carpet. The resident had		the visual/audible screen in an effort to continue to monitor the resident's actions and confirm current interventions remain appropriate. The resident will be placed back on more frequent monitoring should patterns of restlessness increase. The resident's fall care plan has been updated to reflect all current interventions, (See Attachment A). Based upon the resident's diagnosis of dementia the staff will approach the resident from the front in a calm and reassuring manner so as to lessen the resident's potential for fear. The aforementioned has been added to the resident's plan of care, (See Attachment B). The current fall interventions for the resident have been reviewed by the Interdisciplinary team, the resident's legal representative and the physician. All are in agreement the least restrictive measures are in place in an effort to prevent recurrent falls with injury. All other residents who have incurred falls within the last 30 days were again reviewed by the interdisciplinary team to confirm interventions remain effective. It was confirmed there is an Individual Tracking Log in place for each resident who has incurred a fall. Should a fall occur, the nurse on duty is responsible to conduct the post fall investigation, identify efficacy of interventions in place and determine any immediate	

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	oxygen delivered via nasal cannula. The oxygen tubing was stretched across the room. Resident #8's record was reviewed on 6/22/16 at 2:48 p.m. The record indicated Resident #8 was admitted to the facility on 08/5/2015. Diagnoses included, but were not limited to, macular degeneration and Alzheimer's dementia. The Minimum Data Set (MDS) assessment, dated 6/6/16, indicated Resident #8 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The assessment indicated the resident was visually impaired and was at risk for falling. A post fall investigation report, dated 8/9/15 at 7:45 a.m., indicated staff found Resident #8 on the floor in front of the wheel chair. An Interdisciplinary Team (IDT) note indicated a dycem (non-slip pad) was added to the resident's wheelchair on 8/10/15. A post fall investigation report, dated 9/3/15 at 9:00 a.m., indicated staff found Resident #8 with bruises on the face and left arm and the resident reported the fall occurred when returning to bed after going to the bathroom by herself. The resident sustained a fractured left		additional intervention. Following ensuring the safety of the resident, the nurse shall contact the DON to notify the DON of the fall, the interventions in place at the time of fall and any interventions added. The DON will then contact the Administrator to review and confirm the aforementioned process. Both the DON and the Administrator will maintain a copy of the Individual Fall Logs (providing data as to last/past fall(s), circumstances, and interventions in place. In this manner, immediate review shall be conducted to ensure any additional measures were implemented and monitoring increased (i.e., one-on-one implemented) as necessary. As all falls are reviewed by the interdisciplinary team in morning meeting, the aforementioned process will ensure immediate review and increased measures should a fall occur and the next scheduled meeting be more than 24 hours (i.e., occur on the weekend). As a means to ensure ongoing compliance, the fall prevention program policy and procedure has been reviewed and revised, (See Attachment C). A roster/list of all fall interventions in place shall be maintained and the nurse shall be responsible to confirm the implementation/use of each intervention prior to beginning each tour of duty. Should non-compliance be observed, corrective action	

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	humerus. An IDT note indicated a toileting plan every 2 hour was implemented on 9/4/15. A physician's progress note, dated 9/4/15, indicated Resident #8 had a left proximal humerus fracture. A nurse's note, dated 11/7/15 at 8:50 p.m., indicated the alarm sounded, the Certified Nurse Aide (CNA) entered the room as Resident #8 was entering the bathroom. The note indicated the resident was found on the floor lying on her left side with a laceration to the left forehead, above the eye, that had a large amount of red drainage and with bruising. The resident had a skin tear on the back of the right hand and on the inside of the right elbow. The resident complained of pain in the left leg and did not want to bear weight. A post fall investigation report, dated 11/7/15 at 8:50 p.m. indicated staff heard the resident's alarm sounding and went to Resident #8's room. The CNA witnessed the resident fall when the resident was going to the bathroom. The resident sustained injuries of a laceration to the forehead and a fracture. An IDT note, dated 11/9/15, indicated the toileting schedule was changed to hourly.		(including disciplinary action, as necessary) shall be implemented. The DON/designee shall confirm the continued monitoring/confirmation of fall interventions in place through daily audits on scheduled days of work (i.e., visually observing the shift to shift check-off of interventions in place). As a means of Quality Assurance, the Interdisciplinary Team shall continue to review each fall during morning meeting, specifically reviewing the Individual Fall Intervention Log and audibly reviewing the last fall(s) within the last quarter prior to the current fall, each intervention implemented and efficacy thereof. Said reviews will be documented on the morning meeting minutes to be reviewed by the Regional Director/Designee during at least weekly visits to the facility. IDR rationale **BreckenridgeHealth & Rehabilitation IDRRationale F323** **NOTE*The following summary is provided. Corresponding exhibits will be sent to ISDH(attention Susie Scott) via U.S. mail due to the volume of the exhibits.** Per the 2567, *"the facility failed to ensure*	

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	A physician's progress note, dated 11/9/15, indicated Resident #8 was seen at the orthopedic surgeon's office to obtain a cast to left wrist due to fracture and a brace to left hip/pelvis due to fracture of left greater trochanter. A physician's progress note, dated 11/10/15, indicated Resident #8 fell and fractured the left wrist and indicated a fractured left humerus that was 6 weeks old. A post fall investigation report, dated 12/1/15 at 1:10 p.m., indicated Resident #8 had an unwitnessed fall and was on her bottom in front of the wheelchair. An intervention of a self-releasing seat belt was added to the wheelchair and the resident was to lie down after lunch. A nurse's note, dated 12/1/15 at 1:30 p.m., indicated the pressure alarm sounded and Resident #8 had fallen out of the wheelchair. The note indicated a seatbelt alarm was added as an intervention. A physician's progress note, dated 12/1/15, indicated Resident #8 had depression and was prescribed Prozac, was in severe pain, had multiple fractures, dislocated shoulders, and was very frail. Prognosis was guarded.		*adequatesupervision and interventions to prevent a resident identified at risk forfalls from falling 9 times in 10 months resulting in a fractured left humerus(long bone of arm), fractured left greater trochanter (hip), fractured righthip, fractured left wrist and a laceration to the forehead."* While the resident did incurmultiple falls and did unfortunately incur injuries, the facility contends itimplemented interventions and extended efforts (with the support of the legalrepresentative and the physician). The following summary serves to provide asummary of survey events and prior efforts of the facility. Breckenridge Health & Rehabilitation wasnotified on 6/23/16 at 1:15 p.m. the facility was deemed to be in ImmediateJeopardy which involved "Falls without adequate supervision and interventionsthat effectively prevented recurrent falls with	

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	A post fall investigation report, dated 1/9/16 at 6:10 a.m., indicated staff heard the alarm sounding. The resident had an unwitnessed fall and was found on the floor mat. The resident had a skin tear on her elbow. An IDT note, dated 1/11/16 indicated the intervention of a low bed was considered effective. A nurse's note, dated 1/25/16 at 1:00 p.m., indicated a CNA found Resident #8 sliding out of bed to crawl on the floor. The alarms were sounding and the call light was in reach but had not been used. The resident indicated she was going to the bathroom and was seeking a nurse to change her bandage. A post fall investigation report, dated 1/25/16 at 1 p.m., indicated staff witnessed Resident #8 fall from bed onto the floor mat when going to the bathroom. An IDT note, dated 1/26/16, indicated the low bed was considered effective. A post fall investigation report, dated 2/27/16 at 8 a.m., indicated Resident #8 had an unwitnessed fall, was found seated on the toilet with skin tears on bilateral arms, and the alarm had not sounded. An IDT note, dated 2/29/16, indicated the floor mat was changed to a		injuries/fractures for Resident#8." This notification was provided the facility with no signature of surveyorand no signature of person receiving notice **(SEE EXHIBIT #1)** Resident #8 was admitted to Breckenridge Rehab on8/5/15 at 86 years of age, and weighing less than 100 pounds. She hadpreviously incurred falls at home, and per x-ray report provided to thefacility dated pre-admission 7/31/15, "Osseous structures are demineralizedconsistent with the patient's age" and "Impression: 2. Osteopenia" (i.e.,decreased bone density). **(SEE EXHIBIT #2).** Resident #8 was admitted with diagnoses includinghypertension, weakness, macular degeneration, osteoporosis, depression,pneumonia and coronary artery disease. She was ordered Fosamax (forosteoporosis), and Atenolol, Felodipine and Quinapril (all for hypertension) **(SEE EXHIBIT #3).** Upon admission, it was	

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	" landing mat " and the alarm batteries were replaced. An initial psychiatric evaluation, dated 4/11/16, indicated Resident #8 had depressive mood and confusion. A recommendation was made for Namenda XR for dementia. The record did not indicate an evaluation to address delusions tracked by the facility regarding the resident's belief that staff would cause her to fall. A nurse's note, dated 4/24/16 at 7:00 a.m., indicated the Resident#8 was walking to restroom and the nurse "ran into room" as the resident began to fall. The nurse "had to sit her down before we both fell." The resident had a skin tear on the left, upper, posterior arm. A fall incident report, dated 4/24/16 at 5:15 a.m., indicated staff responded to the alarm and witnessed the resident fall against the bed as staff entered the room. The resident had a skin tear on the left upper arm. An IDT note, dated 4/26/16, indicated vital signs were to be checked for 3 days for orthostatic hypotension (decreased blood pressure when changing from lying to sitting to standing positions). Vital signs indicated the blood pressure dropped when the resident changed from sitting to standing. Vital		determined Resident #8 wouldbest be monitored if admitted to Room 100, which is closest to the nurse's station(**SEE EXHIBIT #4-denoting admission toRoom 100),** as this would permit Resident #8 to be monitored more closely bynursing staff due to history of falls. An initial Fall Risk Assessment was completed on8/5/15 and acknowledges the resident has a score of 21 (with a resident whoscores a 10 or higher being at higher risk of falls) (**SEE EXHIBIT #5)** A careplan was initiated on 8/5/15 addressingmultiple risk factors for falls, including history of falls, impulsivebehavior, and poor safety awareness related to impaired balance, dx of CAD,CHF, dementia, anxiety, depression, arthritis, osteoporosis, poor vision,highly impaired hearing and impaired cognition. **(SEE EXHIBIT #6).** One should note this careplan was reviewed andupdated with new interventions repeatedly	

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	signs were obtained on 4/25/16 at 10 a.m. and indicated a sitting blood pressure of 112/62 that dropped to 104/50 when the resident stood. On 4/26/16 at 11:30 a.m. vital signs were obtained and indicated a sitting blood pressure of 117/72 that dropped to 96/50 when the resident stood. On 4/27/16 at 2 p.m. vital signs were obtained and indicated a sitting blood pressure of 118/68 that dropped to 104/60 when the resident stood. The record did not indicate the physician was notified of the resident's drop in blood pressure when the resident stood. A mood and behavior communication memo, dated 4/27/16, indicated Resident #8 was ambulating in her room when staff entered the room. The resident held the nurse's hand and became verbally aggressive toward staff. The resident stated, " You're gonna (sic) make me fall. " The resident sat on bed and chair, but stood back up. Staff remained in the room and the resident smacked staff and stated, "Come on...Stay away from me...You're gonna (sic) make me fall." Interventions for the delusional behavior were food and fluids, 1:1 supervision with the resident, reassurance, time to calm and re approach. The mood and behavior monthly flow record for May 2016 had no documented delusions		throughout the resident's admission. Resident #8 was started on physical therapy on Thursday8/6/15 (one day after admission) due to history of fall in an effort to restorestrength, balance and activity tolerance. She was seen through 10/22/15 **(SEE EXHIBIT #7).** Occupationaltherapy was initiated on 8/7/15 (two days after admission) due to history offall and to increase independent safetywith ADLs and related mobility. She was seen through 11/6/15 **(SEE EXHIBIT #8).** On Saturday, 8/9/15-, Resident #9 was seated in herwheelchair when she crawled out of her w/c and laid on the floor in front ofthe nurse's station; she covered herself with a blanket and incurred no injury.Resident #8 stated she "crawled out of chair and laid on the floor." Anincident report and post fall investigation was completed by the facility **(SEE EXHIBIT #9).** The facility initiated the use of dycem in	

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	A post fall investigation report, dated 5/27/16 at 12 a.m., indicated Resident #8's alarm was sounding and the resident was on the floor when staff responded. The resident complained of hip pain and was sent to the hospital. The resident had a fractured right hip that required surgical repair. An IDT note, dated 5/27/16, indicated an intervention of non-skid socks to be worn when in bed was added. A nurse's noted, dated 5/27/16 at 2:00 a.m., indicated the nurse heard Resident #8's alarm sounding and found the resident on the bedside mat on her knees. The resident had a skin tear on the right, upper, posterior arm and on the wrist. She had a purple bruise on the right hand, a cut on the left, middle finger along with a purple bruise. The resident complained of pain to her right hip and was unable to bear any weight. The resident was transported via ambulance to the hospital and the resident's family member informed the facility the resident was admitted to the hospital and required surgery due to a fracture of the right hip. A physician's progress note, dated 5/31/16, indicated Resident #8 had a history of Alzheimer's type dementia and was blind. Resident #8 recently suffered a fall and was taken to hospital for a right total hip repair. Blood pressures were low		theseat of the wheelchair. Although the resident stated she crawled from thechair, the incident was reviewed as a fall during the next Interdisciplinarymorning meeting held on Monday, 8/10/15, at which time the intervention ofdycem to the wheelchair seat was again reviewed and no further interventionswere deemed appropriate by the interdisciplinary team at this time (**(SEE EXHIBIT #10).** An Individual Fall Monitoring Log was initiated byadministrative nursing on 8/9/15 in an effort to begin tracking falls,specifically evaluating the root cause of the fall (i.e., listing location,what resident was doing at the time, adaptive equipment in use at the time ofthe fall, environmental considerations, significant medications in the 12 hourspreceding the fall, staff witnesses, injury sustained, and any trends noted) **(SEE EXHIBIT #11).** One should note Resident #8 was already on physicaland occupational therapy caseload	

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	and had been recorded as 62/46 and 86/59. Staff were holding Atenolol (blood pressure medication) at that time. A physician's order, dated 6/7/16, indicated Felodipine ER (blood pressure lowering medication) 10 mg by mouth daily, originally prescribed 12/7/15, was discontinued due to hypotension (low blood pressure). Side effects for this medication, listed in the 35th edition of the Nursing 2015 Drug Handbook included, but was not limited to dizziness. A physician's order, dated 6/7/16, indicated Atenolol (blood pressure lowering medication) 25 mg (milligram) twice daily, originally prescribed 8/5/15, was discontinued due to hypotension. Side effects of this medication, listed in the 35th of the Nursing 2015 Drug Handbook included, but were not limited to, dizziness, fatigue, vertigo, hypotension, bradycardia (low heart rate), and drowsiness. A physician's progress note, dated 6/7/16 , indicated Resident #8 had an old cerebrovascular accident (CVA) and dementia. She had a right hip replacement on 5/27/16 and was hypotensive (low blood pressure) with blood pressures running in the 80's/50's.		at this time and therapies continued. On Tuesday 8/11/15, Resident #8 was seen byphysician. Per MD progress note, the physician describes Resident #8 as veryfragile with pain all over. He added duragesic 12 mg in an effort the residentcould participate with physical therapy **(SEEEXHIBIT #12).** The physician also added Calcium 600 mg and Vitamin D dailyfor osteoporosis (**SEE EXHIBIT #13).** Pleaseagain note Resident #8 remained on Fosamax for osteoporosis as previouslyordered upon admission. As the resident had been in the facility for threeweeks, denied “falling” on 8/9 (rather, stating she crawled from the wheelchairand placed herself on the floor), the facility again assessed Fall Risk percompletion of the Fall Risk Assessment on 8/25 (**REFER TO EXHIBIT #5).** The resident continued to be identified bythe facility as at risk for falls, and continued to be seen by both physicaland	

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	A physician's recapitulation, dated June 2016, indicated Fentanyl 12 mcg (micrograms) patch, apply one patch to skin every three days was prescribed 9/8/15 and was a current medication. Side effects listed in the 35th edition of the Nursing 2105 Drug Handbook included, but were not limited to, sedation, dizziness, confusion, and hallucinations. A physician's recapitulation, dated June 2016, indicated Xanax (anti-anxiety medication) 0.25 mg give one tablet by mouth at bedtime was prescribed on 5/3/16 and was a current medication. Side effects listed in the 35th edition of the Nursing 2105 Drug Handbook included, but were not limited to, confusion, drowsiness, light-headedness, sedation, fatigue, and impaired coordination. A care plan, dated 8/12/15, with revision dates of 11/7/15, 9/3/16 (sic), 12/1/15, 2/27/16, 4/24/16, and 5/27/16, indicated the resident had multiple risk factors for falls related to medications of Xanax, Remeron, Prozac, Lasix, and Duragesic patch. Interventions to be implemented included, but were not limited to every 2 hour toiled program with implementation date of 9/3/16 (sic) and discontinued		occupational therapies. It was also on 8/25/15, it was identified andcareplanned the resident was often refusing ADL assistance, showers, and wasnot using the call light **(SEE EXHIBIT#14).** On 9/3/15, "CNA reported resident was complaining ofleft shoulder pain. Nurse assessed and found large bruise on left side of face,laceration to left eyebrow and abrasion to left elbow. Resident told this nurseshe fell against bathroom door taking herself to the restroom, but residentreported to Administrator that she bumped her head on her bedside table. Neurochecks were initiated **(SEE EXHIBIT #15).** Due to resident complaint of pain, an x-ray wasordered on 9/3/15 with results stating, "Two views of the left humerusdemonstrate osteopenia and acute impacted subcapital fracture." (**SEE EXHIBIT #16).** Please again note the resident was beingtreated with medications due to osteoporosis and osteopenia, was being seen	

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	11/7/15, low bed pressure alarm with implementation date of 9/3/16 (sic), toileting program implemented hourly on 11/7/15, bolster mattress implemented 11/7/15, self-release seat belt, implemented 12/1/15, lay down after lunch implemented 12/1/15, change to a landing mat 2/27/16, medication review for othostatic blood pressure checks times 3 days was implemented 4/24/16, non-skid socks when shoes are off was implemented 5/27/16, and PT/OT evaluation recommended 5/27/16. A care plan, dated 5/4/16, indicated Resident #8 had delusions due to dementia and believed staff would harm or make her fall. Interventions included gentle explanation of false belief and introduce evidence to prove why it is not true, attempt to ascertain the potential for harm to self or others, and approach from the front, make eye contact, speak in a calm low tone of voice at a volume easily heard by the resident. A care plan for fall prevention, dated 6/15/16, indicated interventions of: self releasing seat belt alarm at all times, re-educated on use of call light, bed in low position at all times with floor mat and sensor alarm next to the bed, and wear non skid socks when shoes were off. The care plan did not indicate		byboth OT and PT due to weakness and falls, and was rejecting ADL assistance andidentified by her daughter as independent, and would not call for assistance. The fracture incurred by Resident #8 was reported toISDH as per ISDH guidance (**SEE EXHIBIT #17-Incident #3).** The facility determined additional interventions tobe implemented 9/3/15 including every two hour toileting program and low bedwith pressure alarms to bed and wheelchair at all times. The careplan wasupdated accordingly **(REFER TO EXHIBIT#6)** and the fall was added to the Individual Fall Tracking Record (**REFER TO EXHIBIT #11)** in an effort tocontinue to assess root cause, trends, and efficacy of interventions. On 9/3/15, social services spoke with the daughter.Per SS note, “Resident is non-compliant with call light. Will not ask forassistance. Today resident fell coming out of bathroom. Complaining of	

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	revisions were made with each fall when the interventions in place were not effective in preventing falls. A care plan for decreased vision, dated 6/15/16, indicated interventions of: approach from the front, provide assistance with ADL's as needed, inform the resident of her surroundings as needed, and refer to optometrist as needed. A CNA assignment sheet provided by Social Service Director (SSD) on 6/23/16 at 4:05 p.m., indicated Resident #8 was incontinent of bowel at times and had a Foley catheter. The assignment sheet also indicated Resident #8 was to have a pressure alarm at all times, seatbelt alarm when up in wheelchair, sensor alarm aimed toward bed, and to make sure resident had on non skid socks. During an interview on 6/23/16 at 2:24 p.m., the DON indicated Resident #8 had poor safety awareness and they tried to re-educate the resident on using the call light for help. The DON indicated the falls were discussed in the morning meetings and they had not been able to identify a root cause for the falls. She also indicated the facility noticed some falls occurred after meal times. Staff was instructed to toilet Resident #8 and lay		severeshoulder pain. Sent to ER to evaluate and treat. Talked with resident daughterabout it. Daughter states that she has never been compliant with anything." **(SEE EXHIBIT #18).** Following this conversation social servicesadded a notation on the careplan regarding rejection of care stating, "Residentdaughter states she will not ask for help. Very independent." **(REFER TO EXHIBIT #14).** Per physical therapy treatment note dated 9/3/15,"Patient had a fall today while taking self to the bathroom. Patient was upwithout rolling walker using bedside table to lean on. Patient fell on tablewhen it gave out. Nursing reports that patient fractured shoulder in the fall.Patient was educated following fall of importance of using rolling walker whentransferring and ambulating. Patient will have alarm in place upon return tofacility per therapy recommendation. Skilled intervention included patienteducation of safety.	

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	her down in bed after meals. Glasses were not worn by the resident due to her macular degeneration and did not help the resident. During an interview on 6/24/16 at 1:15 p.m., nurse consultant indicated the low bed intervention was effective because the resident rolled out of bed instead of falling. During an interview on 6/24/16 at 2:00 p.m., CNA #1 indicated she toileted the residents on the 100 hallway (where Resident #8 resided) every 2 hours and as needed. During an interview on 6/27/16 at 12:18 p.m., the DON indicated Resident #8's non-compliance for waiting for assistance from staff for ambulation was addressed by re-direction and educating the resident to ask for help before getting up. During an interview on 6/28/16 at 9:07 a.m., the DON indicated Resident #8's medications were reviewed by the facility on 4/24/16 after her fall. Blood pressure medications were being reviewed due to resident having low blood pressures. Blood pressure medications were later discontinued per doctor on 6/7/16. Monthly pharmacy reviews for		Care plan attended with patient's family members, familystill wants patient to return to home following rehab stay." (**SEE EXHIBIT #19).** The 9/3/15 fracture and interventions implementedwere reviewed by the Interdisciplinary Team during meeting held on 9/4/15 **(SEE EXHIBIT #20).** Additionally, the resident was visited by herphysician the next day following the fall (**SEEEXHIBIT #21).** Resident #8 continued on PT and OT caseload andinterventions were in place. Resident #8, who was being closely monitored by herattending physician, was seen again on 9/11/15. Per progress note, "the patientstates she is extremely weak, bedridden, not eating well, has severe arthritisin both shoulder and knees. I injected the shoulder several times on the right.Sleeps a lot. She does not seem to be severe pain. Chest few crackles. Heartsounds regular. IMPRESSION: Severe degenerative arthritis of the	

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	September 2015 through May 2015, excluding November 2015, did not indicate concerns of medication side effects that may attribute to the resident's falls. A facility policy, dated 10/2014, identified as current and titled, "Fall Prevention Program," provided by the Administrator on 6/24/16 a 10:25 a.m., indicated, "... It is the policy of this facility to identify any resident who is at increased risk for falls. Identified residents shall be monitored by the Interdisciplinary Team (IDT) in an effort to implement fall prevention interventions that minimize occurrence of falls thereby minimizing resident risk of injury...." The Immediate Jeopardy that began on 9/03/15 was removed on 6/28/16 at 3:45 p.m., when the facility re-educated staff to the fall prevention policy and implemented a monitoring and supervision program for Resident #8 with criteria for changing the monitoring frequency and duration based on the resident's needs. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to a need for continued fall prevention		shoulders,knees and back **(SEE EXHIBIT #22).** Two days later, on 9/13/15, staff completed aBehavior Communication Memo reporting to the Interdisciplinary Team, “Patientgot up and tried to walk self to restroom. This nurse heard alarm and went toinvestigate. Patient kept pulling at staff and refused to wait while staffunhooked oxygen. Patient has been asked multiple times to use call light andwait for staff assistance. Patient was reminded again to use call light and towait for staff assistance.” **(SEE EXHIBIT#23)** Please note the intervention of the alarm did alertstaff to assist the resident. The resident continued to remain in room 100(closest to the nurse’s station), and OT and PT continued. It was clearResident #8 was not going to notify staff per use of call light, and continueddeteriorating cognition warranted interventions other than reminding to use thecall to call	

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	training and monitoring to ensure appropriate level of supervision for residents identified with fall risk. 3.1-45(a)(2)		for staff and/or education on safety. Thus, the otherinterventions of room location, use of alarms to alert staff of independentambulation, etc. Resident #8 was again seen by her attendingphysician on 10/11/15. Per progress note, he injected 1cc of Kenalog and notedSevere Osteoarthritis. (**REFER TO EXHIBIT#22).** Resident #8 was again seen by her attendingphysician on 10/20/14, stating “Patient is having lots of pain. She has got thefractured left shoulder which should be healed by now, but the right shoulderis not moving and it has fluid in it. I aspirated 2 cc of thick fluid, injected1 cc of Kenalog.” **(SEE EXHIBIT #24)** On 10/22/15, Physical Therapy was discontinued dueresident had met all goals at a level she was able with continued non weightbearing to left upper extremity for six more weeks (per PT Discharge Summary). On 11/6/15, Resident #8 was also discontinued fromOccupational Therapy.	

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			On 11/7/15, per Incident Report, “CNA statedresident got self up to go to bathroom. Pressure alarm sounding. CNA went inand resident in bathroom, then turned to come out. Lost balance, fell to flooron left side. **(SEE EXHIBIT #25).** Order for x-ray obtained and x-rayrevealed, “age related osteopenia and minimally displaced acute transversefracture involving the distal radius and ulna with adjacent soft tissueswelling.” **(SEE EXHIBIT #26)** The fracture of the wrist was reported to ISDH perISDH guidelines **(SEE EXHIBIT #27-Incident #6).** A revised intervention of toileting every one hour (asthe resident was not requesting assistance) was implemented. The fall was reviewed by the Interdisciplinary Teamon Monday, 11/9/15 and the team concurred with the intervention of theincreased frequency of toileting every one hour (**SEE EXHIBIT #28).** Please note the resident continued to have fallsentered	

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			on the Individual Fall Tracking Log, monitoring for surroundingcircumstances of falls and interventions in place **(REFER TO EXHIBIT # 11).** Resident #8 was hospitalized from 11/7- 11/9/15. Upon return to the facility on 11/9/15, MD orders dated11/9 included "sensor alarm next to bed and bolstered pressure reductionmattress to low bed at all times." **(SEEEXHIBIT # 29).** New interventions were implemented and careplannedaccordingly. Resident #8 was visited by her attending physicianon 11/10/15 and 11/11/15. **(REFER TO EXHIBIT# 24)** Resident #8 was again visited by her attendingphysician on 11/24/15. Progress notestates, "She has severe degenerative arthritis of the shoulders with chronicpain. At this point I will start her on some Remeron 15 HS to see if it willincrease her appetite, to help her sleep and pain. Prognosis is not good. Sheis extremely old and frail." **(SEE EXHIBIT #30)**	

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			On 11/24/15, a quarterly review was conducted of theresident's Fall Risk Assessment acknowledging Resident #8 to continue to be atrisk for falls (**REFER TO EXHIBIT #5).** On 12/1/15 per Incident Report, "Called to residentroom by QMA. Resident sitting on floor on buttocks in front of wheelchair.Moves extremities right side without difficulty. Denies pain to fractures onleft side. Vital signs stable. Assisted off floor with assist of two and inbed. Resident denies hitting head. Neuro checks within normal limits."Immediate actions/interventions included: direct supervision when up inwheelchair, seatbelt alarm and resident to be laid down after lunch. **(SEE EXHIBIT #31).** Per Nurse's note dated 12/1/15, " QMA reported thatresident had fallen out of wheelchair while nurse was on lunch. DON and ADONpresent to assist with assessment at time of fall.	

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			Resident slid forward out ofwheelchair onto floor in room, pressure alarm sounded. No injuries present.Resident denies pain/discomfort. Family aware discussed using seat belt alarmas an intervention when up in wheelchair. Family pleased. MD aware. New orderfor seatbelt alarm received. No distress noted." **(SEE EXHIBIT #32).** The fall was discussed during the Interdisciplinary TeamMeeting held on 12/2/15, and the team concurred with the intervention of layingthe resident down after lunch. **(SEEEXHIBIT #33).** The resident was seen by her attending physician on12/29/15. Per progress note, "She has rheumatoid arthritis. It doesn't seem tobe painful. In fact, she is moving it well. Her shoulders- The pain is down. Wehave tapped them and injected them. She looks like she is doing extremely well.I thought she was dying a month ago. I don't think it is gout. It is really notthat tender. I think will observe it and see it next week if it is still red.No signs	

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			of cellulitis." **(SEE EXHIBIT#34).** As resident's six weeks of non weight bearing toupper extremity was expiring, she was again picked up for occupational therapy services on12/31/15 and by physical therapy services on 1/1/16. The goal was to maintainthe resident at her at her highest practicable level. It was evident Resident#8 was going to continue to attempt to transfer, etc., and would likely notcall for assistance or heed to educational attempts due to decreasingcognition. Thus, increasing her strength appeared beneficial to the resident.Occupational therapy was ordered 3 days per week for ADLs, therapeuticexercise, wheelchair management, and patient/caregiver education. Physicaltherapy was ordered three days per week for therapeutic exercise, gait trainingand patient/caregiver training. **(SEEEXHIBIT #35).** On 1/9/16 per Incident Report, "Patient found on matnear bed. Left elbow skin tear noted. No other injuries or complaints	

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			noted.Alarms on and in place sounding." Neurochecks were completed. The current interventions of low bed with bolsters, matand alarm were noted and prevented significant injury, thus would be continued.The resident did incur a skin tear; however, the resident's skin was veryfragile. (**SEE EXHIBIT #36).** The incident was reviewed by the InterdisciplinaryTeam on Monday 1/11/16 and interventions were noted to be effective, thuscontinued. **(SEE EXHIBIT #37).** The IndividualFall Tracking Record continued to be maintained and monitored by administrativenursing. On 1/25/16 per Incident Report, "Resident crawleddown off of bed and onto floor, witnessed by CNA entering room. Residentstated, "I have to go the bathroom to take a shit." Alarms were in place andfunctioning. The immediate action/intervention was to continue with low bed andfloor mat. **(SEE EXHIBIT #38).** Interventionsof alarms, low bed and mat were	

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			effective, thus continued. Please note Resident #8 continued on PT and OTcaseload at this time. The Incident was reviewed by the InterdisciplinaryTeam on 1/26/16, and the intervention oflow bed and mat was deemed to continue to be effective. **(SEE EXHIBIT #39).** Quarterly review of the Fall Risk Assessment wascompleted on 2/2/16, and Resident #8 continued to be identified at risk forfalls (**REFER TO EXHIBIT #5).** Resident #8 was visited by her attending physicianon 2/9/16, during which time "the patient has pain in the wrist. It looks likeit is gout. She has had some swollen joints before. I gave her a shot of Kenalog and check her uric acid." **(REFERTO EXHIBIT #34)** Resident #8 was discharged from Physical therapy andOccupational therapy on 2/25/16. While specific goals were not met, theresident had met her maximum therapeutic potential. On 2/27/16 per Incident	

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			Report, "Observed residentsitting on toilet in bathroom. Both arms bleeding from left upper and new lowerskin tear and new skin tear on right arm. Resident states, she fell, no othersigns of injury noted. Alert and oriented as usual. Bed alarm was notworking." Per investigation, the reportreads the alarm on bed was on, but not working. Per interview with the residentshe stated she slid on low bed mat. The batteries in the alarm were replaced(please note function was being checked every shift-however, batteries haddied). Geri-sleeves were implemented and the mat in use was revised to a"landing mat" to mitigate the risk of injury/tripping should the resident againbe successful with rising lacking staff notification. **(SEE EXHIBIT #40).** The incident was reviewed by the InterdisciplinaryTeam on 2/29/16. The team concurred with the change of the mat to a landing matwith contoured edges. **(SEE EXHIBIT #41).**	

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			The interventions continued without furtherincident. Resident #8 was sent to ER on 4/1/16 and admittedfor evaluation and treatment due to pneumonia and returned to the facility on4/5/16 **(SEE EXHIBIT #42).** Upon return, the Resident's Fall Risk Assessment wascompleted on 4/5/16, deeming Resident #8 to continue to be at risk for falls. **(SEE EXHIBIT #43).** On 4/7/16, Resident #8 was screened and again pickedup by Occupational and Physical Therapy, continually attempting to maintain theresident at her highest practicable level of functioning. On 4/24/16, per Incident Report, "I was outside ofresident's room with my med cart, resident stated she had to use the restroomand proceeded to get up. I came into the room and caught her as she wasstarting to fall to the side. Resident obtained a 1 by .5 cm skin tear to leftposterior upper arm. Steri-stripped area." An immediate	

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			intervention ofconducting a medication review and taking orthostatic blood pressures for threedays was implemented. Results of three day monitoring attached as conducted on4/25-4/27/16 and reported to the physician. (**SEE EXHIBIT #44).** The incident was reviewed by the InterdisciplinaryTeam on 4/26/16, and it was noted the orthostatic blood pressures would betaken. **(SEE EXHIBIT #45)** As a result of the 3 day monitoring and findings,the attending physician on 4/26/16 gave an order to discontinue Atenolol 25 mg BIDrelated to decreased blood pressure, and gave a new order for Atenolol 25 mg dailyfor hypertension. **(SEE EXHIBIT #46).** Per 4/28/16 Social Service note, "Resident washaving a rough day yesterday. Was hitting staff, repetitive verbalization.Delusions, unrealistic fears, paranoia. Staff tried all day to help calm herbut nothing worked. Entire staff took turns walking with her. Family was calledbut	

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			daughter only agitated her more. Finally, she got so worn out in theevening that she wanted to sleep. Daughter wants a walker placed in the roombeside her bed to “keep her from falling.” However, she doesn’t use it unlessshe is reminded then she says no to it. Therapy states that she is contactguard assist because of balance and weakness. Daughter is adamant about walkereven though resident is blind and cannot navigate visually without tripping.Careplan set up with daughter on 5/2/16. **(SEEEXHIBIT #47).** Per physical therapy note dated 5/2/16, “Attendedpatient’s careplan meeting with nursing, social services, administrator, ST.Patient’s daughter stated she would like her mother to have a walker at herdisposal in her room next to her bed. Explained to family that patient requiresCGA/min assist with ambulation due to vision impairments as well as balance andcognitive deficits. It is not advised that patient get up on her own with	

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			orwithout a walker, but with a walker the patient has a tendency to run intothings and get tripped up. If she has someone with her then by all means sheshould and can use the walker for assist." **(SEEEXHIBIT #48).** Per Social Services notes dated 5/2/16, "Careplanfor resident recent behaviors and fall prevention. Administrator, DON, ADON,PT, ST, AD, SSD and daughter. Daughter is still adamant about walker. She feelsthat it will keep her from falling. PT stated that she has four things againsther-blindness, hearing impairment (will not wear hearing aids), balance (poor)and decreased cognition and safety awareness. ST stated that resident scored a4 out of 30 on cognition screen. Safety issues all immense. Completelynon-compliant with assist/treatment. Over the weekend she was hitting staff,being verbally aggressive, delusional, and paranoid. Daughter believes that thebehavior is purposeful and not dementia. PT says that a	

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			walker is more of arisk to resident. DON says they will have staff walk with her every day.Shadows that the resident see are bothering her. Interventions that wereconcluded were to keep her curtains closed at night to keep headlights frommaking shadows on her wall. Talk with the doctor about an anti-anxiety med forincreasing anxiety and fear. Staff will try to keep her busy even though allshe wants to do is go to bed. Work on getting her fried chicken and ham andbeans more often from daughter. **(REFERTO EXHIBIT #47).** On 5/3/16, the physician was consulted and orderedXanax 0.25 mg at HS for anxiety. (**SEE EXHIBIT#49).** The facility was hopeful thiswould assist to lessen agitation and anxiety, thus, lessen risk of attempts atunassisted ambulation. Additionally, the resident's Fall Risk Assessmentwas completed on 5/3/16 (**REFER TOEXHIBIT #43),** indicating the resident continued to be at high risk forfalls.	

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			On 5/29/16 and 5/22/16, resident was documented perBehavior Communication Memos for attempting to get up to go to the bathroom. Onboth occasions, the alarms alerted staff, who then assisted resident with nonegative outcome **(REFER TO EXHIBIT #50).** On 5/17/16, Resident #8 was discharged from physicaltherapy, and on 5/25 was discharged from occupational therapy. On 5/25/16, the physician ordered Namenda inresponse to the resident's decreasing cognition/dementia (**SEE EXHIBIT #51).** On 5/27, per Incident Report, "I was in the processof starting my midnight meds and heard the resident's alarms going off. Istopped what I was doing, locked my cart, and proceeded to resident room whereI found her on the floor on her knees, on the brown mat by her bed. Had visibleskin tears and some bruises on her arms. The evening shift nurse was still hereand she came in to help me. Resident complained of	

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			right hip hurting. Residentcould not bear any weight on her right side." Resident incurred a hip fracture,was sent to hospital for repair and returned to the facility on 5/30/16. **(SEE EXHIBIT #52).** The 5/27/16 fall with fracture was reported to ISDHper ISDH guidance (**SEE EXHIBIT #53-Incident #9).** The fall/fracture was reviewed by theInterdisciplinary Team on the morning of 5/27/16, who noted both shoes andnon-skid socks were off, and resident would continue with PT and OT upon return(**SEE EXHIBIT #54).** Resident #8 was seen by the Nurse Practitioner on5/31/16. She states she is not ambulatory and has diagnoses includingOsteoarthritis and hypotension (**SEEEXHIBIT #55).** Upon return from hip repair, both physical andoccupational therapy picked the resident up for services in an effort to regainability, as possible. The interdisciplinary team continued to seekappropriate	

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			interventions appropriate for the resident as evident per PT notedated 6/1/16 stating, "Nursing wanted patient in Broda due to low bloodpressure and drops even more when she is upright." **(SEE EXHIBIT #56).** The Brodachair was later determined ineffective for the resident. Resident #8 was again seen by the Nurse Practitioneron 6/7/16. **(SEE EXHIBIT #57)** On 6/7/16, resident's blood pressure medicines(Atenolol, Felodipine, Quinepril) were discontinued. **(SEE EXHIBIT #58).** **Summary:** The facility: •□□□□□□□Identified Resident 8's Fall Risk andre-assessed fall risk repeatedly; •□□□□□□□Initiated the Careplan and updated the careplanwith revised interventions, based upon new incidents and intervention efficacy; •□□□□□□□Consistently	

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			communicated with thedaughter and physician as to fall prevention and interventions; •□□□□□□□Discussed the resident's interventionsand efficacy thereof as an Interdisciplinary team; •□□□□□□□Worked with the therapy department, asboth Physical and Occupational therapy had the resident on caseload for thefollowing time periods: ○ Physical Therapy: ▪· 8/6/15through 10/22/15 ▪· 1/1/16through 2/25/16 ▪· 4/7/16through 5/17/16 ▪· 5/31/16through current (at the time of survey) ○ Occupational Therapy: ▪· 8/7/15through 11/6/15 ▪· 12/31/15through 2/25/16 ▪· 4/7/16through 5/25/16 ▪· 5/31/16through current (at the time of survey) •□□□□□□□The physician was closely involved,making routine visits, treating arthritic conditions and pain, in hope to deterthe resident from unassisted attempts at	

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			ambulation. Aletter was provided by the daughter of Resident #8 affirming the multiplemeetings held with the Administrator and staff of Breckenridge Rehab, held on aregular basis (e.g., weekly) to discuss health and measures taken to preventfalls and skin tears. The daughter acknowledges the varied interventionsattempted by the facility, including bed alarms, wheel chair alarms, motiondetectors, lowered bed, floor matting and ensuring the resident was close tothe nurse's station. **(SEE EXHIBIT #59).** Additionallya letter was provided by the attending physician in support of the good faithefforts of the facility to maintain the resident's safety, as possible. **(SEE EXHIBIT #60).** Therecurrent falls of Resident #8 were very unfortunate, and fractures incurredwere reported as per ISDH guidance. However, the	

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			facility does not agree thatit failed to provide adequate supervision and interventions that effectivelyprevented recurrent falls with injury/fractures. The falls were incurreddespite the ongoing implementation, review and revision of interventions,ongoing tracking of falls for root cause, and ongoing involvement of both thelegal representative and the physician. The daughter often requested her motherbe “tied down” stating the only thing that would be effective would be two“boat anchors” attached to her mother, as her mother was going to get up andwas going to attempt unassisted transfer. Thefacility acknowledges encouraging the resident to utilize the call light wasfutile due to the resident’s continued cognitive decline, coupled with theresident’s own insistence on getting up at will. This acknowledgment led tointerventions such as resident’s room being the closest possible to the	

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			nurse'sstation, use of low bed, alarms in bed and chair, toileting every hour, etc. Theinterpretive guidance of F323 states the following: *"The intent of this requirement is to ensure the facility provides anenvironment that is free from accident hazards over which the facility hascontrol and provides supervision and assistive devices to each resident toprevent avoidable accidents. This includes:* *• Identifying hazard(s) and risk(s);* *• Evaluating and analyzing hazard(s) and risk(s);* *• Implementing interventions to reduce hazard(s) and risk(s); and* *• Monitoring for effectiveness and modifying interventions whennecessary. "* Also stated in the interpretiveguidance: *Proper actions followinga fall*	

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			include: *• Ascertaining if therewere injuries, and providing treatment as necessary;* *• Determining what mayhave caused or contributed to the fall;* *• Addressing the factorsfor the fall; and* *• Revising theresident's plan of care and/or facility practices, as needed, to reduce thelikelihood of another fall.* ***NOTE:** A fall by a resident does notnecessarily indicate a deficient practice because not every fall can beavoided.* Thefacility contends a review of the ongoing efforts of the facility as providedin this summary would indicate compliance with the intent of F323 to the extentpossible. Also provided is the following summary of careplan revisions found inExhibit #6: **Summaryof Resident #8 Careplan Reviews Regarding Falls** **(REFERTO EXHIBIT #6)** 8/5/15-Falls Careplan	

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			initiated- Room 100 close to nurse' station, provide adequatelighting, ensure pathways are clutter free, resident to utilize footwear withnon-skid soles, monitor resident frequently when the call lights are notavailable. Physical and occupational therapy initiated following admission. ***8/9/15-Fall Incident Report- crawled out of her w/c and laid on the floor in front ofthe nurse's station; covered herself with a blanket (no fracture);intervention= dycem.*** 8/9/15-re-educated resident on use of call light 8/12/15-careplan reviewed ***9/3/15-Fall with fracture (humerus) Incident Report/Post Fall Investigation, neuro checks- still on OT/PTtherapy*** 9/3/15-initiated every two hour toileting program and low bed with pressure alarm;pull tabalarm 10/21/15-pressure alarm to bed and wheelchair at all times ***11/7Fall- Trying to go to bathroom, lost her balance.***	

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			Fracture (wrist) ***IncidentReport, Post Fall Investigation, neuros done*** 11/7/15-initiated every one hour toileting program; sensor alarm next to bed ***12/1-Fall without fracture-Incident Report/Post Fall investigation in w/c trying toget into bed- new order for self release seat belt; lay down after lunch*** 12/1/15-initiated self release seat belt and lay down after lunch ***1/9/16-8:30a.m. Fall from bed on mat- skin tear -Incident Report/Post Fall investigation,neuros- resident is on bed with bolsters; bolsters continued*** 1/9/16-continue low bed with floor mat as deemed to be effective 1/25/16-continue low bed as deemed to be effective/resident crawled out of bed onto mat ***2/27/16-Found sitting on toilet both arms bleeding; new skin tears- Incident Report,Post Fall Investigation, - Geri Sleeves/changed mat*** 2/27/16-changed type of mat at	

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			bedside ***4/24-Fall-lost balance/intercepted fall- ortho blood pressures times 3 days – skintear- Incident Report/Post Fall and Blood Pressures*** 4/24/16-medication review conducted; orthostatic blood pressure taken for three days ***5/27– Fall- nurse heard alarm- on mat onorders- Incident Report, Post Fall Investigation- hip fracture-Hospital- readmitted 5/30*** 5/27/16-non skid socks when shoes off, continue low bed and alarms; PT/OT evaluation	
F 0332 SS=E 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, interview, and record review the facility failed to maintain a medication error rate less than 5% for 4 of 5 residents reviewed for medication administration. (Residents #16, 24, 25, and 50).	F 0332	F332 Requires the facility to maintain a medication error rate less than 5%. 1.Resident #16 and #50 medications were delivered per pharmacy. Resident #24 and #25 insulin was administered per manufacture guidelines. 2.All residents have the	07/15/2016

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	Findings include: 1. On 6/23/16 at 8:00 a.m., Resident #16 received morning medications from Licensed Practical Nurse (LPN) #3. The medication Buspar (anti-anxiety) was not administered as ordered by the physician. During an interview on 6/23/16 at 8:00 a.m., LPN #3 indicated she was unable to administer Resident #16's morning dose of Buspar because the medication was not available. Resident #16's record was reviewed on 6/28/16 at 8:52 a.m., Diagnoses included, but were not limited to, Alzheimer's dementia and depression. A physician order, dated 5/24/16, indicated Buspar 150 mg (milligram), give one tablet by mouth two times a day. 2. On 6/23/16 at 8:11 a.m., Resident #50 received morning medications from LPN#3. Ferrous Sulfate (Iron supplement) was not administered as ordered by the physician. During an interview on 6/28/16 at 8:11 a.m., LPN #3 indicated she was unable to administer Resident #50's morning dose of Ferrous Sulfate because the medication was not available.		potential to be affected. All resident's medications were reviewed ensuring medication is available to be given. Insulin orders were reviewed ensuring proper times for insulin to be given prior to meals. See below for corrective measures. 3.The nurses were educated on ordering medications in a timely manner so resident's would not miss a dose. If medication is unavailable, the pharmacy should be notified and request that it is sent to the back up pharmacy so it is available to be given per physician's order. Insulin Manufacture guidelines were reviewed with staff ensuring that the nurses are aware when insulin is to be administered with meals. 4.The DON or her designee will observe one medication administration ensuring all medications are given per the physician's order and that insulin in given per manufacture guidelines. If the medication is unavailable, the back up pharmacy should be notified so the medication can be obtained and given per the physician's order. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be	

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	155468	A. BUILDING 00 B. WING	06/29/2016

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	Resident #50's record was reviewed on 6/28/16 at 9:30 a.m., Diagnoses included, but were not limited to, cerebrovascular accident with aphasia and history of anemia. A physician order, dated 6/15/16 , indicated Ferrous Sulfate 325 mg, give one tablet two times a day. 3. On 6/23/16 at 11:33 a.m., Resident #25 received Novolog (fast acting insulin) four units sub-q (subcutaneous) injection per physician order. On 6/23/16 at 12:08 p.m., Resident #25 received his lunch tray in the dining room. Resident #25's record was reviewed on 6/28/16 at 10:21 a.m., Diagnosis included, but were not limited to, type 2 Diabetes, uncontrolled. A physician order, dated, 5/15/16, indicated Novolog per sliding scale sub-q injection with meals and at bedtime. 4. On 6/23/16 at 11:46 a.m., Resident #24 received Novolog 6 units sub-q injection per physician order. On 6/23/16 at 12:06 p.m., Resident #24		reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 15, 2016.	

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	received in his lunch tray in the dining room. Resident #24's record was reviewed on 6/28/16 at 10:37 a.m., Diagnosis included, but were not limited to, Diabetes Mellitus. A physician order, dated, 2/26/16, indicated Novolog 6 units sub-q injection with meals and at bedtime. During an interview on 6/27/16 at 4:00 p.m., the DON indicated the facility follows manufacture guidelines for giving insulin injections within a timely manner of the residents receiving their meal trays. On 6/27/16 at 4:18 p.m., A pharmalogical safety information insert, dated December 2015, was provided by DON and was identified as the current policy the facility used for insulin injections. The insert indicated," ...eat a meal within 5-10 minutes after taking insulin...." A facility policy, dated 10/2014, identified as current and titled, "Medication Administration," provided by the DON on 6/28/16 at 1:12 p.m., included but not limited to, "...1. Medications are to be administered within 1 hour of the scheduled			

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	administration time...." 3.1-48(c)(1)			
F 0371 SS=D 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, interview, and record review, the facility failed to ensure 1 of 1 staff with facial hair wore a beard restraint during 2 of 2 kitchen observations. Finding includes: On 6/20/16 at 9:48 a.m., the Dietary Manager was observed in the food preparation area of the kitchen with uncovered facial hair. On 6/20/16 at 12:05 p.m., the Dietary Manager was observed handing meal trays from the kitchen to staff who served the residents in the main dining room with uncovered facial hair. On 6/27/16 at 12:01 p.m., the Administrator indicated it was the	F 0371	F 371 It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. 1.Upon discovery, the facial hair of the individual was covered. 2.All residents have the potential to be affected. Facial hair of individual was covered immediately. 3.The “Hair Restraints” policy was reviewed and no changes made. All Dietary Staff were educated on the policy on 6/27/16. 4.A dietary designee will be responsible for completing a monitoring sheet at least five times weekly until compliance is maintained (See Attachment F). Five meals a week will need to be observed to ensure facial hair is covered. The Administrator or	07/15/2016

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	facility's policy that hair restraints would be worn by all dietary employees. A policy titled, "Hair Restraints," dated 11/2014, was provided by the Administrator on 6/27/16 at 12:27 p.m. The policy indicated, "Policy: Hair restraints shall be worn by all dietary employees while working in the kitchen area...Procedure: ...2. Men with beards or other facial hair may be required to wear beard protectors...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under "410 IAC 7-24-138: Effectiveness of hair restraint., Sec. 138.... (b) food employees shall wear hair restraints, such as...beard restraints,...that are designed and worn to effectively keep hair from contacting: (1) exposed food; (2) clean equipment, utensils...." 3.1-21(i)(3)		her designee will utilize the monitoring tool weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment F) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5.The above plan was completed on 7/15/16.	
F 0465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure	F 0465	F465 Requires the facility to ensure living environments	07/15/2016

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	living environments were functional and comfortable for 3 of 28 resident rooms reviewed for comfortable living environments. (Rooms #209, #212, and #309). Findings include: On 6/28/16 at 1:02 p.m., during environmental rounds with the Maintenance Director, the following issues were observed: a. Room #209: Two saucer-sized brownish colored areas on the ceiling above the toilet, described by the Maintenance Director as water damage, and a lightbulb in the light fixture above the sink was burned out. b. Room #212: The corner portion of the covebase below the bathroom sink was loose and unattached from the wall. c. Room #309: Two saucer-sized unfinished plastered areas on the wall to the right of the toilet. The lower unfinished area was to the left of the toilet paper dispenser and the highest unfinished area was to the left of the emergency pull cord receptacle. On 6/28/16 at 1:13 p.m., the Maintenance Director indicated he was unaware of the		were functioning and comfortable. 1.Room 209 ceiling was repaired and lightbulb replaced in the fracture. Room 212 covebase in the bathroom was attached to the wall. Room 309 area on the walls in the bathroom was repaired. 2.All residents have the potential to be affected. Resident rooms and bathrooms were assessed for areas needing repair. See below for corrective measures. 3.The Preventative Maintenance Program procedure was reviewed with no changes made. (See attachment E) The Maintenance Supervisor was inserviced on the above procedure. 4.The Administrator or her designee will conduct 5 room audits ensuring in each room and bathroom that no repairs are needed. If repair is needed, the maintenance supervisor will be notified immediately. The Administrator or her designee will utilize the monitoring tool weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment F) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.	

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	areas identified during the maintenance rounds. He indicated when maintenance issues were noticed by staff, a work request form would be completed and placed into a mailbox on the north hall. He indicated he checked the mailbox each day for work request forms. He indicated work requests were prioritized and acted upon immediately. He further indicated the facility had a preventative maintenance program that identified a schedule for routine maintenance of the resident rooms. A policy titled, "Preventative Maintenance Program," dated April 2012, was provided by the Maintenance Director on 6/28/16 at 1:22 p.m. The policy indicated, "...Resident Room Observations: Each resident room should be inspected for potentially needed repairs on a quarterly basis...One should note that the room inspection includes inspection of the resident bathroom...." 3.1-19(f)		5.The above corrective measures will be completed on or before July 15, 2016.	