STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 20, 21, 22, 25, 26, 27, 28, 2016. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census bed type: SNF: 13 SNF/NF: 124 Residential: 41 Total: 178 Census payor type: Medicare: 15 Medicaid: 90 Other: 73 Total: 178 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/3/16 by 29479.	F 0000	Dear Kim Rhoades, This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post-survey review on or after 2/27/2016. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation	

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

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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 interview, the facility failed to maintain residents' dignity by placing labels with the residents' names on wheelchairs. This deficient practice affected 5 of 6 residents reviewed for dignity (Residents' #21, #159, #147, #164, #132). Finding includes: During an observation on 1/20/2016 at 12:30 p.m., Residents #159, #147, #164, #21, and #132 were observed seated in the dinning/activity room in wheel chairs that were labeled with residents' names. During an observation on 1/20/2016 at 2:43 p.m., Resident #159 was observed seated in the dinning/activity room in a wheelchair that was labeled with a residents' name across the back of the chair. During an observation on 1/21/16 at 11:43 a.m., Residents' #159 and #21,	F 0241	It is the practice of this providerthat resident's dignity will be maintained. I. What action has been taken for eachresident cited in the alleged deficiency? Resident names were removed from resident'swheelchairs immediately. II. How will the provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged deficient practice? All residents have the potential to beaffected by this alleged deficient practice. DNS/designee conducted rounds toensure residents did not have names on their person or assistive devices,unless otherwise care planned per family or resident wishes. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? All staff will be in serviced on orbefore 2/23/16 in regards to maintaining resident's dignity by	02/27/2016

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	#147, #146, and #132 were observed seated in the dinning/activity room in wheelchairs that were labeled with the residents' names across the back of the chair. During an observation on 1/22/16 at 2:40 p.m., Resident #21 and #159 were observed seated in the dinning/activity room in wheelchairs that were labeled with their names across the back of the chair. During an observation on 1/25/2016 at 9:52 a.m., Resident #21 was observed seated in the dinning/activity room in a wheel chair labeled with her name across the back of the chair. During an observation on 1/26/16 at 9:43 a.m., Resident #159 was observed seated in the dinning/activity room in a wheelchair labeled with a resident's name across the back. During an interview on 01/26/2016 at 11:48 a.m., Occupational Therapist Assistant #6 indicated labeling residents' wheelchairs was a violation of their privacy. During an interview on 01/26/2016 at 2:12 p.m., the Director of Nursing (DON) indicated wheelchairs should not be		the DNS/designee.The DNS/designee will perform rounds every shift to ensure that no names arevisible on resident's person or assistive devices unless otherwise care plannedper family or resident wishes. Any findings of visible names will be correctedimmediately. IV. To ensure compliance, theDNS/designee will complete the Dignity-Privacy CQI audit tool weekly x 4weeks,Monthly x6 months and then quarterly thereafter. The results of these auditswill be reviewed by the CQI committee and overseen by the ED. If a threshold of100% is not achieved an action plan will be developed to ensure compliance. Systemic changes will be completed by2/27/16	

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	labeled with residents' names. A residents rights policy, identified as current by the Executive Director on 1/28/2016 at 11:00 a.m., indicated residents' dignity would be maintained. 3.1-3(t)			
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being for 3 of 3 residents reviewed for activities (Residents #114, #108, and #91). Findings include: 1. Resident #114's record was reviewed on 1/22/16 at 3:00 p.m. A Minimum	F 0248	It is the practice of this providerthat residents will be provided with activities designed to meet theirinterests. I. What action has been taken for eachresident cited in the alleged deficiency? Activity care plans were reviewed andupdated for resident number 114, 108, and 91. II. How will the provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged	02/27/2016

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	Data Set (MDS) assessment, dated 1/4/16, indicated Resident #114 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 1 out of 15 and required assistance of staff for locomotion on the unit. On 1/20/16 at from 12:19 p.m. to 12:42 p.m., Resident #114 was observed seated at a table in the memory care dining/activity room. She attempted to get up several times but was redirected back to the table by staff and instructed to wait for lunch. She was not provided forms of entertainment, books, or items for cognitive stimulation. The radio was playing music but an activity was not observed. Lunch was served at 12:42 p.m. The posted activity calendar indicated an activity titled "Daily Chores" was scheduled at this time. On 1/21/16 at 9:35 a.m. and 9:43 a.m., Resident #114 was observed lying on a bench by the nurse's station with her eyes open. The posted activity calendar indicated an activity titled "The Good News Club" was scheduled at this time. On 1/21/2016 at 2:53 p.m., Resident #114 was observed wandering into the activity/dining room where activity staff was observed painting residents' nails. Activity staff #1 was heard telling a		deficient practice? All residents residing on the memorycare unit have the potential to be affected by this alleged deficient practice.Memory Care Facilitator/Activity Director for Memory Care conducted an audit ofall resident's on memory care to ensure care plans were updated and reflectcurrent preferences. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? Memory Care activity staff will be inserviced on or before 2/23/16 by the MCF/designee in regards to followingresidents preference for activities. The MCF/designee will perform rounds everyshift to ensure that activities are being conducted and are appropriate and forindividual residents. During quarterly care plan review or with any significantchange in condition, residents care plans will be reviewed and updated toreflect any changes and current activity preferences. IV. To ensure compliance, the MCF/designeewill complete the Cottage Activities CQI audit tool weekly x 4weeks, Monthly x6months, and then quarterly until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQIcommittee and overseen by	

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	Certified Nursing Assistant to "get her." The CNA redirected her away from the activity and back to the bench by the nurse's station. The activity calendar indicated an activity titled "Spa Day" was scheduled at this time. At 3:00 p.m. Resident # 114 was observed lying with her eyes open on the bench by the nurse's station. On 1/25/16 at 9:30 a.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "The Good News Club" was scheduled at this time. On 1/25/16 at 10:30 a.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "Baking Snickerdoodles" was scheduled at this time. On 1/25/2016 at 12:00 p.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "Daily Chores" was scheduled at this time. The activity/Dining room was observed. Several residents were seated at tables in the dining room. One table had wooden blocks in the center. Residents were not observed interacting		the ED. If a threshold of 100% is not achieved anaction plan will be developed to ensure compliance. By what date the systemic changes willbe completed: 2/27/16	

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	with the blocks or each other. Activity staff #2 was observed seated in a chair documenting in a book labeled Activity Participation. Staff was not observed interacting with residents. The activity calendar indicated an activity titled "Daily Chores" was scheduled at this time. On 1/25/16 at 1:30 p.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "Balloon Volleyball" was scheduled at this time. At 1:50 p.m., staff was observed directing residents to the TV lounge by the nurse's station for the balloon volleyball activity. Staff was not observed to invite or encourage Resident #114 to participate. On 1/25/16 at 2:30 p.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "Music with Friends" was scheduled at this time. On 1/26/16 at 9:20 a.m., Resident #114 was observed seated on the bench by the nurse's station interacting with Speech Therapist (ST) #5. At 9:25 a.m., ST #5 escorted Resident #114 to the activity/dining room. ST #5 asked			

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	activity staff to give Resident #114 a snack. Activity staff provided Resident #114 with a snack. Music was playing on the radio and eight other residents were seated around the tables. Resident #114 was observed seated in the dining/activity room from 9:25 a.m. until 9:45 a.m. Resident #114 was not provided forms of entertainment, books, or stimulation. Staff was not observed interacting with Resident #114 or the other residents. The activity calendar indicated an activity titled "Sit and Fit" was scheduled at this time. On 1/26/16 at 10:00 a.m., Resident #114 was observed lying with her eyes open on the bench by the nurse's station. The activity calendar indicated an activity titled "Coffee Club" was scheduled at this time. A comprehensive assessment Minimum Data Set (MDS) assessment, dated 7/21/15, indicated it was very important for Resident #114 to have books, newspapers, and magazines to read, and somewhat important for her to keep up with the news and do things with groups of people. An activity care plan, dated 10/23/15, indicated Resident #114 required reminders to attend group activities of			

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	interest. A goal indicated she would enjoy group activities of interest to her level of satisfaction through the next assessment date. Approaches indicated the facility would invite her to games, provide her with the assistance needed, remind her of bingo and socials, and respect her right to choose activities. An activity attendance document for January 1-26, 2016, was reviewed on 1/26/16 at 11:30 a.m. This document indicated Resident #114 did not attend activities on 13 out of 26 days on January 5, 7, 8, 10, 11, 12, 14, 16, 17, 18, 19, 22, and 26, 2016, and only participated in one activity titled "Daily Chores" on ten additional days January 1, 2, 3, 4, 9, 14, 20, 23, 24, and 25, 2016. The document indicated, "Needs independent tracking everyday if she's not coming to activities." 2. Resident #108's record was reviewed on 1/25/16 at 2:56 p.m. Resident #108 had diagnoses which included, but were not limited to, depression and dementia. A Minimum Data Set (MDS) assessment, dated 10/9/15, indicated Resident #108 had cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 7 out of 15. During an observation on 1/20/16 from			

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	12:19 p.m. to 12:42 p.m., Resident #108 was observed seated in the dining/activity room waiting for the noon meal to be served. She was not provided activities for cognitive stimulation. Music was playing on the radio. Staff was serving drinks. Staff was not observed interacting with Resident #108. On 1/21/2016 at 9:35 a.m., Resident #108 was observed seated in the dining/activity room. A paper titled "Daily Chronicle" was laying on the table in front of her. Four other residents were observed seated in the room. Activity staff #2 was present and the Activity Director was observed in and out of the room. Activity staff was not observed interacting with the residents. Resident #108's eyes were closed during part of the activity. The Activity Calendar indicated an activity titled "Who Am I" was scheduled at this time. On 1/21/16 at 2:00 p.m., Resident #108 was observed lying on her back in bed, eyes opened staring towards the ceiling, with no television or music provided. The activity calendar indicated an activity titled "Sing Along" was scheduled at this time. On 1/21/2016 at 2:39 p.m., Resident #108 was observed lying on her back in			

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	bed, with her eyes opened and staring towards the ceiling. There was no television or music provided. The activity calendar indicated an activity titled "Spa Day" was scheduled at this time. On 1/25/16 at 9:30 a.m., Resident # 108 was observed lying on her back in bed. Her eyes were opened and she was staring towards the ceiling. No music or television was provided. The activity calendar indicated an activity titled "The Good News" was scheduled at this time. On 1/25/2016 at 10:00 a.m., Resident # 108 was observed lying on her back in bed. Her eyes were opened and she was staring towards the ceiling. No music or television was provided. The activity calendar indicated an activity titled "Coffee Club" was scheduled. On 1/25/16 at 10:30 a.m., Resident # 108 was observed lying on her back in bed. Her eyes were opened and she was staring towards the ceiling. No music or television was provided. The activity calendar indicated an activity titled "Baking Snickerdoodles" was scheduled at this time. On 1/25/16 at 10:42 a.m., and 11:48 a.m., Resident #108 was observed seated in the			

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	dining/activity room drinking lemonade. A paper titled "Daily Chronicle" was laying on the table in front of her. She was not observed looking at the Daily Chronicle. An activity was not observed occurring at this time. Staff was not observed interacting with Resident #108. The activity calendar indicated an activity titled "Daily Chronicle" was scheduled at this time. On 1/25/2016 at 12:00 p.m., Resident #108 was observed wheeling herself out of the activity/dining room. Several residents were observed seated at tables in the dining/activity room. One table had wooden blocks placed in the center. Residents were not observed interacting with the blocks or each other. Activity staff #2 was observed seated in a chair documenting in a book labeled Activity Participation. Staff was not observed interacting with residents. The activity calendar indicated an activity titled "Daily Chores" was scheduled at this time. On 1/25/16 at 1:00 p.m., Resident #108 was observed seated in the activity/dining room with her head in her hand and her eyes closed. Activities were not occurring. The Activity Director and other activity staff was present. Staff was not observed interacting with her. At			

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	1:33 p.m., she was observed wheeling herself out of the activity/dining room. The activity Calendar indicated an activity titled "Balloon Volleyball" was scheduled at this time. On 1/25/16 from 1:33 p.m. to 2:30 p.m., Resident #108 was observed wheeling herself up and down the two hallways on the unit. At 1:50 p.m., staff was observed gathering residents for the balloon volleyball activity. The Activity Director and other activity staff was present. Staff was not observed to invite or encourage Resident #108 to participate. On 1/26/2016 at 9:12 a.m., Resident #108 was seated in the dining/activity room with her head tilted to her chest and her eyes closed. A paper titled "Daily Chronicle" was laying on the table in front of her. Staff was not observed encouraging her to participate in the activity A comprehensive MDS, dated 10/9/15. indicated it was somewhat important to Resident #108 to have books, newspaper, and magazines to read, very important to her to listen to music she liked, be around animals, keep up with the news, do things with groups of people, do her favorite activities, go outside to get fresh air when			

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	the weather was good, and participate in religious services or practices. The MDS indicated she required assistance from staff for locomotion on the unit. An activity care plan, dated 12/23/15, indicated Resident #108 enjoyed snack time, cooking, bingo, and pet visits. A goal indicated she would attend at least two activities a day. Approaches indicated staff was to invite and encourage her to attend activities. An activity attendance document for November 1, 2016 through January 26, 2016, was reviewed on 1/26/16 at 11:30 a.m. The document indicated Resident #108 was provided one or fewer activities on twenty out of thirty days in November on 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 21, 22, 24, 25, 29, and 30, fourteen out of thirty-one days in December on 12/3, 5, 6, 7, 8, 12, 13, 17, 18, 21, 23, 25, 27, and 31, and five out of twenty-six days in January on 1/2, 8, 9, 15, 20. 3. Resident #91's record was reviewed on 1/25/16 at 3:23 p.m. Resident #91 had diagnoses which included, but were not limited to, anxiety, depression, and Alzheimer's disease. A Minimum data Set (MDS) assessment, dated 12/23/15, indicated Resident #91 had cognitive			

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	impairment with a Brief Interview for Mental Status (BIMS) score of 5 out of 15. During an interview on 1/22/16 at 11:31 a.m., Resident #91's family member indicated staff had not encouraged her to attend activities nor provided assistance for her to attend them. She indicated she visits her mother three days a week and when she comes in her mother was usually in her room or seated in the dining room not participating in activities. She indicated her mother had a lot of anxiety and was concerned about her tearful outburst and had just this week conversed with staff regarding her lack of activities. On 1/25/16 at 10:38 a.m., Resident #91 was observed ambulating down the hall crying. She was overheard saying to the nurse "I guess my mom didn't get to come today. I thought for sure my mom would come today." The nurse was overheard telling Resident #91 "let's go to the ding room for an activity." On 1/25/16 at 10:42 a.m., and 11:48 a.m., Resident #91 was observed seated in the dining/activity room. A paper titled "Daily Chronicle" was laying on the table in front of her. She was not observed looking at the Daily Chronicle. An			

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	activity was not observed occurring at this time. Staff was not observed interacting with Resident #91. The activity calendar indicated an activity titled "Baking Snickerdoodles" was scheduled at this time. On 1/25/16 at 11:00 a.m., Resident #91 was observed ambulating in the hall way. The activity calendar indicated an activity titled "Who Am I" was scheduled at this time. On 1/25/2016 at 12:07 p.m., Resident #91 was observed seated in the dining/activity room. The paper tabled Daily Chronicle remained on the table in front of her. Activity staff #2 was observed documenting in a book tabled Activity Participation. Occasionally she would look up and read from the Chronicle. She was not observed to encourage or interact with Resident #91. The activity calendar indicated an activity titled "Daily Chores" was scheduled at this time. During an observation on 1/25/16 at 1:25 p.m., Resident #91 was overheard asking the Activity Director "What do I do now?" The Activity Director was overheard telling Resident #91 "You can go to your room or watch TV." Resident #91 was observed leaving the			

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	activity/dining room. The activity calendar indicated an activity titled "Balloon Volleyball" was scheduled at this time. At 1:38 p.m., Resident #108 was observed going to her room. On 1/25/2016 at 1:53 p.m., a balloon volleyball activity was observed occurring in the TV lounge. Resident #91 was observed in her bed with her eyes closed at this time. During an observation on 1/25/16 at 2:30 p.m., Resident #91 was observed in her bed with her eyes closed, no TV or music playing. The activity calendar indicated an activity titled "Spa Day" was occurring at this time. A Minimum data Set (MDS) assessment, dated 4/2/15, indicated it was very important for her to have books, newspapers, and magazines to read, to keep up with the news, do things with groups of people, do her favorite activities, and go outside to get fresh air when the weather was good. An activity care plan, dated 12/28/15, indicated Resident #91 had Alzheimer's disease as well as other health problems, which could impact her desire to participate in group activities. The plan indicated Resident #91 was provided			

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	with one on one activities. A goal indicated "with encouragement, cues, and reminders" she would participate in group activities of interest through the next assessment date. Approaches indicated the facility would encourage and assist her with sewing and crocheting as needed, encourage daily socialization outside of her room, encourage family visits, encourage participation in scheduled programming, and respect her right to choose activities. In addition, a one on one activity care plan, dated 1/21/16, indicated Resident #91 would be provided 2-3 one to one activities per week beginning 1/21/16. An activity attendance document for November 1, 2016 through January 26, 2016, was reviewed on 1/26/16 at 11:30 a.m. The document indicated Resident #91 was provided one or fewer activities on twenty-six out of thirty days in November on 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, and 30, twenty-nine out of thirty-one days in December on 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, and 31., and twenty-two out of twenty-six days in January on 1/1, 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26.			

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	The record indicated she was provided a one on one activity on 1/21/16 for 15 minutes and 1/22/16 for 30 minutes. During an interview on 1/26/16 at 9:34 a.m., Activity Staff #5 was queried regarding the content of the scheduled activities. She indicated the following: a. Music in Motion- music played and residents encouraged to exercise. b. Good News Club-reading of and encouraging conversation about the Daily Chronicle. c. Coffee Club - serving coffee and/or drinks. d. Baking Snickerdoodles- baking snacks. She indicated it was not done as scheduled on 1/25/16 because they "were out of supplies." e. Daily Chores-She indicated it "use to be" an activity where residents placed table clothes on the tables for meals but the table clothes had been "gone" for "about four weeks ." She indicated she didn't know why it was still on the schedule. f. Music with Friends - interactive music activity. g. Spa Day - nails, hand massages. h. Afternoon with Snack- snack and drink. During an interview on 1/26/2016 at 9:26			

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	a.m., Activity staff #1 indicated she wasn't aware of individualized activity care plans. She indicated the only activities provided were those posted on the schedule. She further indicated they just began one on ones activities for a few residents but Resident #114 was not one of them. She indicated Resident #114 would benefit from individualized one on one activities such as "brushing her hair, make-up, walking, and talking with her." She indicated Resident #108 was appropriate for group activities but needed reminded and assisted to attend. She indicated Resident #91 loved to bake and talk about her family. She further indicated Resident #91's daughter was concerned about her being depressed and had requested one on one activities this week. During an interview on 01/26/2016 at 9:51 a.m., Activity staff #2 indicated she documented activity participation if residents were "physically" present for activities. She indicated she documented passive participation when residents "sleep" through an activity. She indicated residents are documented actively present for the activity titled "Daily Chores" if the resident is present for lunch. During an interview on 1/26/2016 at			

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	11:56 a.m., the memory care Activity Director (AD) indicated staff should have interacted with residents during activities. She indicated residents who slept during activities should have been offered the opportunity to lie down. The AD indicated she had not purchased the supplies needed for baking activities. She indicated a system was not currently in place to ensure Residents were provided individualized meaningful activities. She indicated she was new in her position and she had just began implementing one on one activities. She indicated Resident #114 needed one on one activities and they had not provided her with them. She indicated meaningful one on one activities were provide on Cottage 3 but not Cottage 2. She indicated Resident #108 was appropriate for the scheduled activities but staff did not always "go out and invite and encourage her to attend." She indicated the facility had just began one on ones activities with Resident #91. She indicated she was instructed not to document if residents refused activities and therefore did not have a way to monitor and assess refusal of activities. An Activity Policy, identified as current on 1/26/16 at 3:31 p.m., indicated, "...The activity department will develop a calendar of activities that reflects the			

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	needs and interest of the residents...any changes to the calendar will be posted on the calendar... It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...." 3.1-33(a) 3.1-33(c)			
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 interview, and record review the facility failed to ensure medications were discontinued and not administered as ordered by the physician for 1 of 5 residents reviewed for unnecessary medication (Resident #45). Findings include: Resident #45's record was reviewed on 1/22/2016 at 9:58 a.m. Resident #45 had	F 0282	It is the practice of this provider Itis the practice of this provider to arrange services by qualified persons inaccordance with each resident's written plan of care. II. What corrective actions will beaccomplished for those residents found to have been affected by the allegeddeficient practice: This alleged deficient practice was immediately corrected byupdating medication administration record to correctly	02/27/2016

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	diagnosis which included, but was not limited to, edema. A physician's order, dated 11/30/15, indicated an order for Lasix 20 milligrams (mg) daily for edema. A physician's order, dated 12/30/15, indicated an order to discontinue the Lasix. A Medication Administration Record (MAR) dated January 1-22, 2016, was reviewed on 1/22/16 at 11:00 a.m. The record indicated Resident #45 received Lasix (diuretic) 20 milligrams daily from January 1 to January 21, 2016. During an interview on 1/22/2016 at 9:58 a.m., Registered Nurse (RN) #11 indicated Resident #45 was currently still taking Lasix and it was administered that morning. During an interview on 1/22/2016 at 9:58 a.m., Nurse Practitioner (NP) #13 indicated the Lasix was discontinued 12/30/15, but was administered to Resident #45 daily through 1/22/16. She indicated she would order labs to ensure adverse consequences. A lab record, dated January 1/22/16 at 1:42 p.m., indicated a basic metabolic panel had been obtained and the results		reflect physician'sorders. MD/family immediately notified of incident. Resident was not adversely affectedby this alleged deficient practice. II. How other residents having thepotential to be affected by thesame deficient practice will be identified and what corrective actions will betaken: All resident's have the potential to be affected by this allegeddeficient practice. Licensed nurses will accurately transcribe all physicians'orders to the medication administration record.All current orders for all residents were audited for accuracy on or before 2/23/16.Re-education to all nurses will be completed on orbefore 2/23/16 by the DNS/designee. Re-education included proper transcriptionof all physician orders. III. What systemicchanges will be taken to ensure the alleged deficient practice does not recur? The nurse receiving the physicianorder is responsible for noting it accurately on the medication administrationrecord. The licensed nurses scheduled for third shift will ensure all ordersfrom previous day have been transcribed correctly to the medicationadministration record. All nurses checking the orders are toinitial that the order was checked and transcribed accurately. Unit	

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	were within normal limits. During an interview on 01/26/2016 at 2:48 p.m., RN #11 indicated when the order was discontinued they failed to remove the order from the MAR which resulted in Resident #45 being administered the Lasix after it was discontinued. On 01/25/2016 at 10:00 a.m., the Director of Nursing indicated the facility did not have a policy regarding updating the MAR when an order was discontinued. 3.1-35(g)(2)		manager/designeewill also be responsible for ensuring all new orders have been transcribedcorrectly daily. Education to all nurses on the new facility policy forensuring accuracy for physician's orders will be completed by the DNS/designee onor before 2/23/16. IV. How the corrective actions will bemonitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place; and by what date the systemic changeswill be completed: Education to all nurses on the new facility policy forensuring accuracy for physician's orders was completed on or before 2/29/16. All new nursing hires will beeducated during orientation on this policy. Daily audits will be conducted bythe unit manager/designee to ensure all orders have been transcribedaccurately from the previous day. Any discrepancies will be communicated to theDirector of Nursing immediately. Weekly" Transcription of Physician's Orders" CQI audits will be completedby nurse management weekly x 4, monthly x 3, then quarterly thereafter for atleast 6 months and all data will be submitted and reviewed at the monthly CQIteam meetings. If the	

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			100% threshold is not met, an action plan will bedeveloped. Quarterly refresher in-services will be conducted on the policy forensuring accuracy for physician's order transcription. By what date the systemic changes willbe completed: 2/27/2016	
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on observation, interview, and record review, the facility failed to ensure pain medication was administered to manage pain prior to incontinence and wound care to a resident resulting in verbal and non-verbal expressions of pain during the procedures for 1 of 3 residents reviewed for pain management (Resident #110). B. Based on record review and interview, the facility failed to ensure communication between the facility and dialysis provider for 1 of 1 residents reviewed for dialysis (Resident #14). Findings include:	F 0309	It is the practice of this Provider to ensurepain management is provided during care and dressing changes. It is thepractice of this provider to ensure communication between facility and dialysisprovider. I. What action has been taken for eachresident cited in the alleged deficiency? -MD was notified of resident number110 exhibiting signs and symptoms of pain during incontinent care and dressingchanges. New pain medication order received and monitored for effectiveness. -Resident number 14 no longer residesat facility. II. How will the Provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this correct	02/27/2016

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	A1. During an observation of wound care on 1/26/2016 at 9:54 a.m., the Assistant Director of Nursing (ADON) Resident #110's removed Resident #110's multipodus boots was positioned sitting up, with multipodus boots (pressure relieving boots) and wound dressings from the bilateral heels as he sat up in his wheel chair. The resident moaned and made facial grimaces during the wound care. The ADON indicated Resident #110 experienced pain during his dressing changes. During an observation of incontinence and wound care on 1/27/2016 at 12:01 p.m., with Certified Nursing Assistant (CNA) #61, CNA #62, and Registered Nurse (RN) #63 present, Resident #110 was transferred by a hoyer lift to his bed to receive incontinence care. The resident moaned and stated, "Ouch, ouch," during care and made facial grimaces when staff provided the care. One hour after care was initiated, the resident was transferred from his bed via Hoyer (mechanical lift) lift to his wheelchair and was given Morphine (narcotic pain medication) 0.25 ml (milliliters) for pain relief. Resident 110's record was reviewed on 1/25/2016 at 12:00 p.m. Resident #110 had diagnoses which included, but were not limited to, osteoporosis, peripheral		this alleged deficient practice? - All residents have the potential tobe affected. DNS/ Designee will complete a new pain assessment on all residentsby 2/23/16. Any residents withidentified or assessed pain will be addressed. -All dialysis residents have the potentialto be affected. All charts for residentsreceiving dialysis were audited. Communication to dialysis providers was madeby DNS to ensure communication forms are completed and returned with residentsupon return from dialysis. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? -All nursing staff will be educated byDNS/designee by 2/23/16 on Pain Management. Prior to any treatment, the nurse will assessany for any pain. If pain is not controlled, medication will be administeredper physician orders to effectively address pain.The assessment will be documented on the TAR. DNS/designee will audit the MAR/TARdaily to ensure pain is assessed and that medication anddressing changes are administered as prescribed by physician. -All licensed nurses will be educatedby the DNS/designee on policy for communication between dialysis provider andfacility on or before 2/23/16. All new licensed nurse hires will be educated onthe policy for dialysis communication in orientation. IV. How will the	

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	vascular disease, neuropathy, chronic kidney disease, type 2 DM, and pressure ulcers. A pain care plan, dated 11/3/2015, and identified by the Administrator as current on 1/28/2016 at 12:23 p.m., indicated Resident #110 had pain related to peripheral vascular disease, osteoporosis, gastroesophageal reflux disease, gout, and neuropathy. Strength; able to describe pain characteristics and efficacy of interventions. Potential for pain related to wounds. A goal indicated resident will be free from adverse effects of pain. Interventions indicated staff would administer medications as ordered, assist with positioning to comfort, document effectiveness of prn medications, notify the doctor if pain is unrelieved and/or worsening, observe for non verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, change in posture, and to offer non pharmacological interventions such as a quiet environment, rest, shower, back rub, and reposition. A physician's order, dated 11/5/2015, indicated orders for palliative care/comfort measures only.		corrective action bemonitored or what quality assurance program implemented to ensure the allegeddeficient practice does not recur? To ensure compliance, observations of care will be completed by DNS/designee to ensure pain management during procedures/care ice weekly for one month then monthly x 5 months. TAR audits will becompleted by the DNS/Designee weekly x 4 weeks then monthly x 6. The result ofthese audits will be reviewed by the CQI committee overseen by the ED. If a thresholdof 95% is not achieved, an action plan will be developed to assure compliance By what date the systemic changes willbe completed: 2/27/2016	

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	A physician's order, dated 11/20/2015, indicated orders for Roxanol (narcotic pain medication/Morphine Sulfate 20 milligrams/1 milliliters solution, give 0.25 milliliters (5 milligrams) sublingually every 4 hours as needed. A physician's order, dated 12/1/2015, indicated orders for Hydrocodone (narcotic pain medication) 5-325 milligram tab, take 1 tablet by mouth 3 times daily. A Minimum Data Set assessment (MDS) tool, dated 12/28/2015, indicated Resident #110 had exhibited vocal complaints of pain (ouch, that hurt, stop) to staff for 1 to 2 days within the past 5 days. The record indicated Resident #110 was cognitively intact with with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Resident #110 required extensive assistance of 2 staff members with bed mobility and transfers, and extensive assistance of 1 staff member with toileting. A wound consult report, dated 1/26/2016, indicated, Resident #110's "ulcers persisted for a litany of reasons. Chief among them are:...2. Muscle pain/stiffness, resulting in difficulty repositioning resident without significant discomfort...."			

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	Resident 110's medication administration record (MAR), dated January 2016, and Resident 110's PRN flow sheet were reviewed on 1/27/2016 at 1:05 p.m., with Registered Nurse (RN) #60 present. The MAR indicated Resident #110 was administered routine Hydrocodone pain medication at 6:00 a.m., 2 p.m., and 10 p.m. on 1/26/2016 and at 6:00 a.m. on 1/27/2016. The record lacked indication he had been administered the routine Hydrocodone pain medication after 1/27/2016. The record lacked indication Resident #110 had received the ordered as needed Roxanol narcotic pain medication on 1/27/2016 prior to his observed incontinence care at 12:01 p.m. During an interview on 1/26/2016 at 11:39 a.m., the Wound Physician indicated Resident #110 had muscle pain and had exhibited discomfort and pain with repositioning. During an interview on 1/26/2016 at 1:05 p.m., RN #60 indicated she had not administered Resident #110's as needed dose of Morphine prior to Resident #110's incontinence care and had not yet administered his routine Hydrocodone pain medication scheduled for 2 p.m. During an interview on 1/27/2016 at 3:29			

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	155620	A. BUILDING 00 B. WING	01/28/2016

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	p.m., Resident #110 indicated his buttocks was very sore. He indicated "it hurts" when the staff reposition him while in bed. During an interview on 1/28/2016 at 10:54 a.m., with the Director of Nursing (DON), Administrator, and the ADON, the DON indicated if a resident was experiencing pain during care, she expected her staff to halt the care provided, assess pain, and provide pain relieving interventions and/or pain medication immediately before continuing care. She indicated she expected her staff to assess and document uncontrolled pain for the interdisciplinary team to review. A policy titled, "Pain Management," dated 2/2015 and identified as current by the DON on 1/28/2016 at 11:13 a.m., indicated, "Policy: It is the policy of [name of facility corporation] to provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well being, including pain management. It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keeping the resident as comfortable and pain free as possible...the pain management program will be determined			

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	based upon staff observation of non-verbal signs of pain as follows: non-verbal sounds (crying, whining, gasping, moaning, or groaning)...vocal complaints of pain (that hurts, ouch, stop)...residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass...the licensed nurse will monitor the efficacy of the analgesia and keep the physician informed of any indicators of drug or dosage change as it relates to the resident's pain management...." B. Resident #14's record was reviewed on 1/26/16 at 10:58 a.m. The admission Minimum Data Set (MDS) assessment, dated 12/8/15, indicated Resident #14 received dialysis. The care plans, dated 12/14/15 and 12/22/15, stated Resident #14 was, "receiving hemodialysis." The nursing progress notes, dated from 12/15/15 to 1/26/16 were reviewed. Vitals were documented post dialysis on dialysis dates, but the record lacked documentation of communication with the dialysis center. The physician order summary, dated 12/29/15, indicated Resident #14 had a			

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	diagnosis included, but was not limited to, end stage renal disease and the record indicated the resident received hemodialysis three days a week. During an interview on 1/26/16 at 2:09 p.m., Registered Nurse (RN) #60 indicated they did not have a dialysis communication binder and the forms sent back and forth to communicate with dialysis should be in the resident's chart under the dialysis tab. No forms were filed under the dialysis tab in Resident #14's chart. RN #60 indicated she was not Resident #14's nurse and there may have been another process for dialysis communication for that resident. During an interview on 1/26/16 at 2:18 p.m., RN #35 indicated there was no communication form or binder that was sent with or sent back with Resident #14 from the dialysis center. She indicated they did not call the dialysis center for a report or have report called to them from the dialysis center. During an interview on 1/26/16 at 3:18 p.m., the Assistant Director of Nursing (ADON) indicated she was unaware Resident #14 did not have a communication form being sent with him or returned with him when he went to dialysis.			

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	On 1/20/16 at 1:30 p.m., the Administrator provided the current dialysis contract with the requested entrance conference material. The contract titled, "SNF Outpatient Dialysis Services Agreement," dated 8/14/08, stated, "...The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD Residents, including a Registered Nurse as a contact person at the Nursing Facility whose responsibilities include oversight of provision of Services to the ESRD Residents...Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD Dialysis Unit." On 1/20/16 at 1:30 p.m., the Administrator provided the current dialysis policy with the requested entrance conference material. The policy titled, "Dialysis Care," dated 1/2015, stated, "...The nurse in charge at the time of transfer to dialysis will provide the resident with all appropriate paperwork as required by the Dialysis Unit...The nurse in charge at time of return will review paperwork for new orders and/or paperwork accompanying the resident."			

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	3.1-37(a)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to identify and assess stage 2 pressure ulcers (partial thickness skin loss) on a resident ' s right and left buttocks and failed to implement interventions to prevent pressure ulcers from developing or deteriorating resulting in a resident developing a stage 3 pressure ulcer (full thickness skin loss) to the left heel and an unstageable pressure ulcer (depth of tissue damage is not able to be determined due to presence of nonviable tissue) to the right heel, and to prevent another resident who was admitted without pressure ulcers from developing an unstageable pressure ulcer that healed and recurred as a stage 3 pressure ulcer on the right hip for 2 of 3 residents	F 0314	It is the practice of this providerthat residents will not develop pressure sores unless the individual's clinicalcondition demonstrates that they were unavoidable; and a resident havingpressure sores receives necessary treatment and services to promote healing,prevent infection and prevent new sores from developing. I. What action has been taken for eachresident cited in the alleged deficiency? For resident 110: MD/familyimmediately notified with new alteration in skin integrity and a new treatmentorder was obtained. Wounds to buttocks have since resolved. All other skininterventions in place and remain appropriate. For resident 192: Skin interventions reviewed, obtained orderfor air mattress	02/27/2016

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	reviewed for pressure ulcers (Residents #110 and #192). Findings include: 1. Resident #110 was observed on the following dates and times for pressure prevention interventions and wound care: a. 1/22/2016 at 2:57 p.m.- up in wheel chair with multipodus boots to bilateral feet on his wheelchair foot pedal. His low air loss mattress was set to level 5. b. 1/25/2016 at 9:46 a.m.- up in wheel chair with multipodus boots to bilateral feet on his wheelchair foot pedal. Roho cushion was placed in his wheelchair seat. His low air loss mattress was set to level 6. c. 1/25/2016 at 12:49 p.m.- up in new tilt wheel chair provided by therapy, with multipodus boots to his bilateral feet placed on the wheel chair foot pedal. A roho cushion was not observed in Resident #110's wheel chair. d. 1/25/2016 at 4:16 p.m.- up in tilt wheel chair in his room. A roho cushion was not observed in Resident #110's wheel chair. His low air loss mattress was set to level 6. e. 1/26/2016 at 9:54 a.m., with the Assistant Director of Nursing (ADON) present, Resident #110's wounds to his heels were observed. The left heel wound		ordered to promote wound healing. Care plan reviewed andreflects residents continued refusal of wedge or pillows for repositioning whenin bed. II. How will the provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged deficient practice? All residents have the potential to beaffected by this alleged deficient practice. DNS/designee conducted skin sweepson all residents to ensure all altered skin integrity was identified and propertreatments were in place for existing altered skin conditions. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? Nursing staff will be in serviced onor before 2/23/16 in regards to procedure for reporting any new skin issuesidentified and pressure wound prevention by the DNS/designee. The DNS/designeewill perform rounds every shift to ensure that all preventative skin treatmentsare in place. DNS/designee will review facility activity report daily to checkfor any new or worsening skin events to ensure MD has been notified and newtreatment order have been obtained. IV. To ensure compliance, theDNS/designee will perform rounds every shift to ensure that all preventative skin treatments are in place, accuracy of wound	

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	was observed as a stage 3 pressure ulcer, with a beefy red wound bed that contained white slough to the upper and outer edges, minimal serosanginous (containing both blood and serum) drainage, and without odor. The right heel wound was observed as an unstageable pressure ulcer with a wound bed containing 75% eschar. The lower edge of the wound contained beefy red tissue. The wound was without drainage, slough, or odor. The ADON indicated Resident #110 did not have any additional pressure ulcers. f. 1/26/2016 at 3:49 p.m.- up in tilt wheel chair with multipodus boots to bilateral feet placed on foot pedal. A roho cushion was not observed to wheel chair. g. 1/27/2016 from 12:01 p.m. to 12:58 p.m., with Certified Nursing Assistant (CNA) #61, CNA #62, and Registered Nurse (RN) #63 present, Resident #110 was observed to receive incontinence care. Resident #110 was transferred into bed by a Hoyer (mechanical lift) lift and placed on his back in bed. His bilateral heel wounds were wrapped with Kerlix (gauze bandage) and no drainage was observed through the dressings after his multipodus boots were removed from his bilateral feet in bed. A heel up device was placed directly under Resident #110's heels after he was placed in bed on his back. An open area was observed as a		assessments and efficacy of treatments will be assessed weekly during wound rounds, and DNS/designee will complete the Wound-Skin CQI audit tool weekly x 4weeks,Monthly x6 months, and then quarterly until continued compliance is maintainedfor 2 consecutive quarters. The results of these audits will be reviewed by theCQI committee and overseen by the ED. If a threshold of 100% is not achieved anaction plan will be developed to ensure compliance. By what date the systemic changes willbe completed: 2/27/2016	

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	stage 2 pressure ulcer to both Resident #110's right and left buttock. RN #63 indicated he was unaware of the pressure ulcers before the incontinence care and could not provide documentation of the pressure ulcers. The stage 2 pressure ulcer to the right buttock measured 0.8 cm x 0.4 cm x less than 0.1 cm, with 100% granulation (new connective tissue) and a pink wound bed without drainage or odor. The stage 2 pressure ulcer to the left buttock measured 0.4 cm x 0.7 cm x less than 0.1 cm with 100% granulation and a pink wound bed without drainage or odor. Calmoseptine (barrier ointment) and a foam dressing was placed on both stage 2 pressure ulcers by RN #63. Resident #110 was then transferred by hoyer lift back into his tilt wheel chair with a Roho cushion placed in the wheel chair seat. Brown drainage was observed through both Kerlix dressings to his heel wounds as his multipodus boots were placed to his bilateral feet and placed on the foot pedal of the wheel chair foot pedal. CNA #61 indicated Resident #110 had the open areas to his buttocks during his morning incontinence care. She indicated he had the open areas for some time, couldn't give the exact date, and that she had notified her charge nurse. h. 1/27/2016 at 2:12 p.m.- up in tilt wheel chair with Roho cushion to seat and			

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	multipodus boots to bilateral feet placed on wheel chair foot pedal. i. 1/28/2016 at 10:16 p.m.- up in tilt wheel chair asleep with Roho cushion to chair and multipodus boots to bilateral feet placed on the wheel chair foot pedal. Resident #110's record was reviewed on 1/22/2016 at 12:20 p.m. A "Pressure Wound Skin Evaluation Report," dated 1/19/16, indicated Resident #110 had an unstageable pressure ulcer with necrotic/eschar tissue to the right heel with measurements of 5.5 cm (centimeters) x 6 cm x 0.1 cm. The report indicated Resident #110 also had an unstageable pressure ulcer with necrotic/eschar (dry, dark scab or falling away of dead skin) tissue to the left heel with measurements of 4 cm x 2.3 cm x 0.1 cm. The record indicated Resident #110 had diagnoses which included, but were not limited to, osteoporosis, peripheral vascular disease, neuropathy, chronic kidney disease, type 2 DM, and pressure ulcers. The record indicated Resident #110 had developed a stage 3 pressure ulcer to his left buttocks within 30 days of admission to the facility that had a current status of healed. The record lacked indication protein levels and/or albumin levels had been obtained since the resident's admission. The record lacked indication Resident #110 refused			

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	interventions to prevent or promote healing of pressure ulcers. A care plan, dated 11/3/2015, indicated Resident #110 was at risk for skin breakdown due to requiring assistance with bed mobility, his diagnosis of peripheral vascular disease (PVD, his history of pressure wounds, varied oral intakes, and his incontinence. The care plan goal, dated 2/7/2016, indicated the resident would be free from skin breakdown. Interventions inlcuded: a pressure reducing mattress on bed- low air loss mattress at setting of 5, dated 12/3/2015; assess and document skin condition weekly and as needed and notify physician of abnormal findings, dated 11/3/2015; encourage resident to eat at least 75% of meals; house barrier cream at bedside to use as needed; incontinent care as needed using peri wash and moisture barrier; pressure reducing/redistribution cushion in chair/wheelchair, preventative treatments as ordered, and turn and reposition resident at least every two hours. A physician's order, dated 11/5/2015, indicated orders for palliative care/comfort measures only. An Admission Minimum Data Set assessment (MDS) tool, dated 11/7/2015,			

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	indicated Resident #110 was at risk for developing pressure ulcers and the resident was admitted without pressure ulcers. Skin and ulcer treatments included: pressure reducing device for chair, pressure reducing device for bed, application of non-surgical dressings, applications of ointments/medications. Resident #110 required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting. He required extensive assistance of one person for locomotion and was totally dependent upon staff for bathing. He was always incontinent of both bowel and bladder. He was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. A physician's order, dated 11/18/2015, indicated an order for Resident #110 to float heels while in bed. A care plan, dated 11/19/2015, indicated Resident #110 has unstageable pressure wounds to his bilateral heels with wound healing not anticipated related to his diagnosis of PVD with palliative care and no aggressive measures as per his plan of care. The care plan goal, with a target date of 1/9/2016, indicated his wound would heal without complications. Current interventions included: float heels when in bed, prevalon boots as			

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	ordered, treatment as ordered, assess wound weekly documenting measurements and description, notify physician of worsening or no change in wound or signs of infection, and observe for signs of infection. A physician's order, dated 11/23/2015, indicated Resident #110 was to wear multipodus boots to his bilateral feet at all times. A physician's order, dated 12/3/2015, indicated Resident #110 was to utilize low air loss mattress at setting #5. Check every shift." A physician's order, dated 12/15/2015, indicated, "...Clarification: multipodus boots to bilateral feet at all times when not in bed. Float heels; heel up cushion at ALL times when in bed...." An MDS, dated 12/28/2015, indicated Resident #110 was at risk for the development of pressure ulcers. The record indicated he has 2 unstageable pressure ulcers and had 1 stage 3 pressure ulcer on his prior assessment that has a current status of healed. Skin and ulcer treatments included: pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care, applications of ointments/meds, application of			

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	dressings to feet. The record indicated Resident #110 was cognitively intact with with a BIMS score of 9 out of 15. Resident #110 required extensive assistance of 2 staff members with bed mobility and transfers, and extensive assistance of 1 staff member with toileting. A review of Resident #110's Medication Administration Review (MAR), dated 1/1/2016 to 1/31/2016, indicated Resident #110 to utilize LAL [low air loss] mattress with setting #5 and nursing to check every shift. The record indicated the nursing staff documented Resident #110's mattress was at setting 5 on 1/25/2016 from 11 to 7 p.m., 7 a.m. to 3 p.m., and 3 p.m. to 11 p.m. Resident #110's Wound Consult reports were reviewed on 1/26/2016 at 12:30 p.m. The records indicated Resident #110 was first assessed by the wound physician on 11/24/2015, with the bilateral heel wounds first observed on 11/18/2015. The left heel was a stage 3 pressure ulcer with measurements of 1 cm x 1.2 cm x 0.1 cm. The right heel was a necrotic tissue unstageable pressure ulcer with measurements of 3 cm x 9 cm x 0.1 cm. The 11/24/2015 wound report indicated, "...continue to float at all times to reduce the risk of further pressure			

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	injury...elevate BLE [bilateral lower extremities] at rest to promote venous return...." The 12/1/2015 wound report indicated both heels were unstageable pressure ulcers, with the left heel measurements of 4.2 cm x 4.2 cm x 0.1 cm, and right heel measurements of 4.5 cm x 4.8 cm x 0.1 cm. The report also indicated Resident #110 had developed a stage 3 pressure ulcer to his left buttock on 11/24/2015 with measurements of 0.9 cm x 0.6 cm x 0.1 cm. The 12/1/2015 wound report indicated, "...offloading education provided; should remove rigid boots in bed to float heels with heel up device and use boots when not in bed, to avoid pressure to open areas...upgrade to LAL mattress but should also use wedge or pillow beneath hip in bed to avoid direct pressure to buttock...." The 12/22/2015 wound report indicated Resident #110's stage 3 pressure ulcer to his left buttock had received a status as resolved. The left heel remained an unstageable pressure ulcer with measurements of 4 cm x 1.7 cm x 0.1 cm. The right heel remained an unstageable pressure ulcer with measurements of 4.4 cm x 5.8 cm x 0.1 cm. The 12/22/2015 wound report indicated, "Buttock resolved; continue preventive offloading...be sure to continue to offload consistently to avoid new pressure injury (use heels-up device while in bed to float,			

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	and multipodus boots when up in w/c [wheel chair])." The 1/26/2016 wound report indicated the left heel was an unstageable pressure ulcer with measurements of 4.2 cm x 1.2 cm x 0.1 cm. The right heel was an unstageable pressure ulcer with measurements of 4 cm x 5.5 cm x 0.1 cm. The 1/26/2016 wound report indicated, "...Be sure to float heels at ALL times to avoid ongoing pressure...continue to take measures to avoid infection in wounds and to redistribute pressure to avoid further tissue compromise." Resident #110's "Weekly Summary" reports were reviewed on 1/27/2015 at 11:45 a.m. The record lacked documentation of an acquired Stage 2 pressure ulcer to the right and left buttocks before the observation of incontinence care on 1/27/2015 at 12:01 p.m. Resident #110's "Shower Reports" were reviewed on 1/28/2015 at 9:00 a.m. The record lacked documentation that an open area had been observed by nursing staff on the right or left buttock from 12/23/2015 to 1/23/2016. During an interview on 1/25/2016 at 12:02 p.m., the Director of Nursing indicated all residents were reviewed by			

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	the interdisciplinary team upon admission for the risk of skin breakdown, based on mobility and history of pressure ulcers, and interventions are placed into the care plan. She indicated to measure the efficacy of the interventions, the facility staff would have to continually monitor that interventions were in place to ensure pressure ulcer prevention; if skin breakdown occurred, weekly measurements would be assessed; and current interventions would need to be reassessed if not working. She indicated Resident #110 had a history of pressure ulcer development and believed his decrease in mobility contributed to the development of his pressure ulcers, as well as his overall health decline and need for palliative care. During an interview on 1/25/2016 at 1:27 p.m., CNA #61 indicated she would fill out a "Shower Sheet" if a new open area appeared on the resident and report it to her charge nurse. She indicated Resident #110 is compliant with laying down throughout the day. She indicated he received a new tilt wheel chair that therapy provided. She indicated Resident #110 had an open area to his buttocks She indicated Resident #110 did not have a heel up device or an order to float his heels before he developed pressure ulcers to his heels			

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	During an interview on 1/25/2016 at 2:51 p.m., the DON indicated she expected her staff to offload Resident #110's heels prior to his pressure ulcer development to his bilateral heels. She indicated this intervention was not included in his care plan prior to the development of his bilateral heel wounds. She indicated she expected her staff to turn and reposition Resident #110 every two hours, utilize a wheel chair cushion, and was on a pressure reducation mattress, not a low air loss mattress, before 12/3/2015. She indicated she expected her staff to continually monitor the interventions were in place for Resident #110 and indicated she believed his pressure ulcers to his bilateral heels were unavoidable and would not heal. She indicated he did not have a pressure ulcer to his buttocks. During an interview on 1/25/2016 at 3:49 p.m., the ADON indicated that she was unaware if Resident #110's Roho cushion could be placed in his new tilt wheel chair. She indicated Resident #110 was at one time wearing the multipodus boots at all times and staff were expected to off-load heels with pillows while he was in bed. During an interview on 1/25/16 at 4:30 p.m., the Rehab Manager indicated the			

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	Roho cushion can be placed in Resident #110's tilt wheel chair to reduce pressure. During an interview on 1/26/2016 at 11:39 a.m., the Wound Physician indicated the most important intervention to decrease pressure to the heels is to ensure the heels are always off-loading. He indicated any amount of time the heels are not offloaded can increase the risk of pressure. He indicated a low air loss mattress and repositioning is most important for the pressure ulcer prevention and treatment of ulcers to the buttocks. He indicated the multipodus boots should only be worn when resident is up in wheelchair to decrease pressure due to the rigidity of boots creating a possibility of contributing to pressure development and increase if the resident is laying on his back in bed. He indicated Resident #110's healed stage 3 pressure ulcer to his left buttock had been avoidable. He indicated with the resident's history of pressure ulcers to his heels, palliative care plan, vascular status, and discomfort and pain with repositioning, the pressure ulcers to the bilateral heels were unavoidable. During an interview on 1/27/2016 at 11:21 a.m., CNA #61 indicated she transfers Resident #110 into his wheel chair before breakfast and he generally			

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	stays up in his wheel chair through lunch. She indicated he is able to tell her when he would like to lay down in bed. During an interview on 1/27/2016 at 12:58 p.m., CNA #61 indicated Resident #110's heels should not be placed directly on the heel up device. She indicated the heels should off load. During an interview on 1/27/2016 at 3:29 p.m., Resident #110 indicated he had not been laid down into bed since before breakfast. He indicated his buttocks was very sore. He indicated he can tell the staff he'd like to lay down when they ask. He indicated they had asked him once that day if he would like to lay down in bed. He indicated "it hurts" when the staff reposition him in bed. During an interview on 1/28/2016 at 10:55 a.m, the DON indicated that if a new open area is found on the skin, she expected her staff to notify management, the physician and family immediately. She indicated Resident #110's new open areas to the left and right buttocks had not been documented in the weekly skin assessments and she expected her nursing staff to do a skin assessment weekly. 2. On 1/26/16 from 9:35 a.m. to 10:31 a.m., Resident #192 was observed in the			

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	activity area sitting in her wheelchair on a pressure relieving cushion. She was observed to be sitting in the center of the wheelchair and was not observed to be leaning to either side. Staff was not observed to reposition her or address her position in her wheelchair during observation. On 1/26/16 from 10:31 a.m. to 11:01 a.m., Resident #192 was sitting in her wheelchair on a pressure reducing cushion with her left leg crossed over the right knee and leaning slightly to her right side. Staff was not observed to reposition her or address her position in her wheelchair during observation. On 1/26/16 at 1:31 p.m., Resident #192 was sitting in the dining area in wheelchair on the pressure reducing cushion with her left leg crossed over the right knee and was leaning slightly to her right side. On 1/26/16 at 1:58 p.m., Resident #192's right hip wound was observed with Unit Manager (UM) #30 and Certified Nursing Assistant (CNA) #31. Resident #192 was sitting in the center of her wheelchair on a pressure reducing cushion. CNA #31 and UM #30 assisted the Resident #192 to her feet, lowered her pants and pulled back the dressing from her right hip. The			

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	open area on her right hip was approximately the size and depth of a tip of a pen, and red in color with a dark spot at the bottom of the wound. A small amount of brown drainage was observed on the dressing. CNA #31 replaced the dressing, and assisted UM #30 to transfer Resident #192 into her bed. Resident #192 was positioned on her back onto her foam mattress with a pillow under her head only. During the observation, Resident #192 spoke in her native language and only said, "Yes," when UM #30 touched her bed and asked if she'd like to lie down. UM #30 indicated throughout the observation she was unable to understand Resident #192 and wished she could communicate with her. On 1/26/16 at 3:07 p.m., Resident #192 was lying on her foam mattress on her back. No pillow was observed under her right hip. On 1/26/16 at 4:46 p.m., and 1/27/16 at 9:12 a.m., Resident #192 was sitting in the center of her wheelchair on a pressure reducing cushion in the activity area. On 1/27/16 at 10:39 a.m., Resident #192 was lying on her foam mattress on her left side. No pillow was observed behind her back or under her hip.			

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	On 1/22/16 at 10:55 a.m., Resident #192's record was reviewed. The nursing progress note, dated 9/12/15 at 12:43 p.m., indicated Resident #192 was admitted at 4 p.m. and did not have skin issues on admission. The care plan, dated 9/14/15, stated Resident #192 was, "...at risk for skin breakdown due to: requires extensive assist from staff for bed mobility. Incontinent of bowel and bladder." The care plan included the following interventions: " Assess and document skin condition weekly and as needed. Notify MD of abnormal findings, encourage resident to eat at least 75% of meals, house barrier at bedside-use as needed, incontinent care as needed using peri wash and moisture barrier...pressure reducing/redistribution cushion in heelchair (sp), pressure reducing/redistribution mattress on bed, turn and reposition at least every 2 hours." The care plan, dated 9/14/15, indicated Resident #192 was at risk self-care deficit due to cognitive deficits and physical decline. The interventions included, but were not limited to the following: "...assist resident with eating as needed, assist with transfers of one to two staff."			

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	The care plan, dated 9/14/15, stated Resident #192 had, "...potential for unrelieved pain d/t (due to)communication impairment; dx (diagnosis of) dementia and speaks only French." The care plan interventions included, but were not limited to the following: "...assist with position to comfort...observe for nonverbal signs of pain." The care plan, dated 9/14/15, indicated Resident #192 was incontinent of bladder and bowel. The care plan interventions included, but were not limited to the following: "...assess and document skin condition weekly and as needed, assist with elimination, assist with incontinent care as needed." The shower reports, dated 9/15/15 and 9/18/15, indicated Resident #192 had no areas of skin impairment. The admission Minimum Data Set (MDS) assessment, dated 9/18/15, indicated Resident #192 had a brief interview of mental status (BIMS) score of 0 out of 15 and was severely cognitively impaired. The MDS indicated Resident #192 required extensive assistance of two people for bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. The MDS			

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	indicated Resident #192 was at risk for pressure ulcers and was frequently incontinent of bladder and bowel. The shower report, dated 9/22/15, indicated Resident #192 had a complete bed bath and had a red area on her right hip. The form titled, "ASC New Skin Event," dated 9/22/15, indicated Resident #192 had a new pressure ulcer to her right hip that was not present on admission. The form indicated the pressure area measured 3 centimeters (cm) in length by 2 cm in width, and stated the wound was, "dark brown with yellow around it." The form titled, "ASC Pressure Wound Skin Evaluation," dated 9/22/15, indicated Resident #192 had an unstageable (full thickness skin or tissue loss) on her right hip and measured 1.6 cm in length by 1 cm in width by 0.1 cm in depth. The form indicated the wound was 60% slough (yellow fibrinous tissue that consists of fibrin, pus, and proteinaceous material). The nursing progress note, dated 9/22/15 at 5:37 a.m., indicated Resident # 192 had a new open area on her right hip measuring 3 cm in length by 2 cm in width. The note stated the wound had, "a			

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	dark brown center with yellow area surrounding," and no drainage. The note stated, "...Area cleansed and covered with foam dressing. Resident positioned by staff on L (left) side to alleviate pressure to area but noted returning /favoring lying on the R (right) side." Wound Care Specialists of Indiana (WCS) progress note, dated 9/22/15, stated Resident #192 had, "necrotic tissue (unstageable) pressure ulcer," to her right hip. The note noted the wound measured 1.6 centimeters (cm) in length by 1 cm in width by 0.1 cm in depth. The following treatment was ordered, "Cleanse wound bed with NS (normal saline); pat dry. Apply skin prep or barrier cream to wound edges and santyl (ointment) to open area. Cover with foam and secure. Change daily and PRN (as needed)." The progress note stated the plan of treatment would be, "...santyl to enzymatically debride, obtain cushion for w/c (wheelchair)." The shower reports, dated 9/25/15 to 10/20/15, indicated Resident #192 had skin impairment to her right hip. The WCS progress note, dated 9/29/15, indicated the Resident #192's wound had changed from an unstageable to a stage 3 (full thickness tissue loss where bone,			

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	tendon or muscle is not exposed) pressure ulcer and measured 1.5 cm in length by 1 cm in width by 0.4 cm in depth. The note indicated the treatment was to remain the same. The significant change in status MDS, dated 9/30/15, indicated Resident #192 was severely cognitively impaired, and required extensive assistance of two people for bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. The MDS indicated Resident #192 was at risk of developing pressure ulcers, and had one stage 3 pressure ulcer (full thickness tissue loss) that measured 1.5 cm in length by 1 cm in width by 0.1 cm in depth. The WCS progress note, dated 10/6/15, indicated Resident #192 had a stage 3 pressure ulcer on her right hip that measured 1.5 cm in length by 1 cm in width by 0.1 cm in depth. The note indicated the wound treatment was to remain the same and staff was to continue to encourage Resident #192 to stay off her right side despite poor compliance. The physician telephone order, dated 10/6/15 at 2:00 p.m., ordered, "Encourage wedge cushion while in bed to promote resident to lie on L			

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	(left)...side." The treatment record for October 2015, had staff initials for each of the three shifts from 10/8/15 to 10/26/15 indicating the wedge pillow was placed while Resident #192 was in bed. The record lacked documentation that the resident refused the wedge pillow. The WCS progress note, dated 10/13/15, indicated Resident #192 had a stage 3 to the right hip measuring 0.6 cm in length by 0.6 cm in width by 0.1 cm in depth. The treatment was changed to the following, "Cleanse wound bed with NS (normal saline). Pat dry. Apply skin prep or barrier cream to periwound. Apply foam dressing to wound bed and change every 3 days and PRN (as needed), soiled." The WCS progress note, dated 10/20/15, indicated Resident #192 had a stage 3 to the right hip with measurements of 1.4 cm in length by 0.9 cm in width by 0.1 cm in depth. The note stated, "When wedge or pillow is used resident removes and lies on right side regardless." The note indicated the treatment was to remain the same. The shower reports, dated from 10/23/15 to 10/30/15, indicated Resident #192 did			

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	not have skin impairment. The WCS progress note, dated 10/27/15, indicated Resident #192 had a stage 3 pressure ulcer on the right hip. The wound measured 0.4 cm in length by 0.6 cm in width by 0.1 cm in depth. The note stated Resident #192, "...Continues to lie preferentially on ulcerated side; continue to attempt to discourage and/or bolster with wedge or pillow/s (sp) to reduce risk of ongoing pressure injury." The physician telephone order, dated 10/27/15, ordered the wedge cushion to be discontinued because the resident was refusing to use it. The WCS progress note, dated 11/3/15, stated, "...right hip stage 3 pressure ulcer...resolved...no drainage. Wound margin is attached to base...wound bed 76-100% epithelialization...scabbed." The shower reports, dated from 11/3/15 to 12/27/15, indicated Resident #192 did not have skin impairment. The quarterly MDS, dated 12/4/15, indicated Resident #192 was severely cognitively impaired, was always incontinent of bladder and bowel, and required extensive assistance of two for bed mobility, transfer, dressing, toileting,			

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	personal hygiene, and bathing. The MDS indicated Resident #192 was at risk for pressure ulcers, but did not currently have a pressure ulcer. The nurse practitioner progress note, dated 12/15/16, stated Resident #192, "...has had refusal of care/resistance to care but not unusual...this is her baseline." The progress note indicated a urinalysis was ordered due to her behaviors. The physician order summary, dated 12/28/15, indicated the following were ordered on 9/30/15 and were continued: "cushion to wheelchair for pressure relief...House barrier cream to peri cream every shift and as needed...Daily vit (vitamin) to promote skin integrity." The shower report, dated 1/5/16, indicated Resident #192 had redness on her right hip. The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 1/6/16, indicated Resident #192 had a stage 3 pressure ulcer on her right hip, and it was originally found on 1/5/16. The note indicated the wound measured 1.5 cm in length by 1 cm in width by 0.1 cm in depth, and had a small amount of serosanguineous (blood and liquid part of			

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	blood) drainage. . The physician order, dated 1/6/16, ordered the following wound treatment, "Cleanse right hip wound with NS (normal saline) pat dry. Apply thick layer calazime (skin protectant)cream. Cover with foam dressing change daily and prn (as needed)." The care plan, dated 1/7/16, stated Resident #192 had, "pressure wound to right hip (previous wound re-opened). " Care plan interventions included, but were not limited to: "Assess for pain...Assess wound weekly documenting measurements and description...incontinent care as needed and with peri wash and moisture barrier...observe for signs of infection...pressure reducing/redistribution cushion in chair...treatment as ordered...turn and reposition every 2 hours...wound healing vitamins as ordered." The shower reports, dated 1/8/16 to 1/15/16, indicated Resident #192 did not have skin impairment. The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 1/12/16, indicated Resident #192 had an unstageable pressure ulcer to the right			

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	hip. The wound measured 1.7 cm in length by 1.5 cm in width by 0.1 cm in depth. The note indicated the wound had a small amount of serosanguineous drainage. The physician order, dated 1/12/16, ordered the following treatment, "cleanse right hip with NS (normal saline), pat dry. Apply santyl (ointment) cover with foam and secure. Change daily." The WCS progress note, dated 1/12/16, indicated this was the first visit from the wound specialist and the wound measured 1.7 cm in le ngth by 1.5 cm in width by 0.1 cm in depth. The note stated, "Santyl to enzymatically debride; area likely unavoidable due to resident refusal to lie off ulcerated side. Continue to encourage redistribution of pressure." The WCS progress note, dated 1/19/16, indicated Resident #192 had an unstageable pressure ulcer to the right hip that measured 1.1 cm in length by 1.3 cm in width by 0.1 cm in depth. The note indicated wound had a small amount of serosanguineous drainage, and the treatment was to remain the same. The WCS progress note, dated 1/26/16, indicated Resident #192's wound had			

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	changed from an unstageable to a stage 3 pressure ulcer. The wound measured 0.8 cm in length by 0.5 cm in width, by 0.5 cm in depth. The note indicated wound had a small amount of serosanguineous drainage. The note stated, "increased depth is a result of enzymatic activity of Santyl and reduction in slough filling ulcer bed. Cont (continue) Santyl to debride remaining slough; add hydrogel gauze to maintain moisture and fill dead space now that wound has appreciable depth." The physician order, dated 1/26/16, ordered, "clarification... cleanse right hip ulcer with ns (normal saline), pat dry, apply calamine (lotion) to surrounding skin and santyl to wound base, pack lightly with puffed hydrogel-moistened gauze and secure." As of 1/26/16 at 4:22 p.m., the profile section of the computerized chart for Resident #192 indicated staff was to turn and reposition her every 2 hours and as needed while in bed and in chair, and she was to have, "incontinent care as needed using peri wash and moisture barrier. " During an interview on 1/26/16 at 10:49 a.m., Certified Nursing Assistant (CNA) #32 indicated she took care of Resident #192. She indicated was unaware if			

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	Resident #192 needed to be repositioned while up in her wheelchair or while in bed. She indicated she was unaware if there was a specialty cushion on the resident's wheelchair. During an interview on 1/26/16 at 11:50 a.m., Unit Manager (UM) #30 indicated Resident #192 was not on a repositioning schedule, but was to be repositioned every time she was visualized leaning on her right side in her wheelchair. She indicated Resident #192 favored her right side in the wheelchair and while in her bed. During an interview on 1/26/16 at 2:58 p.m., the Assistant Director of Nursing (ADON) indicated Resident #192's pressure area on her hip was acquired in facility both times. She indicated Resident #192 did not have a specialty mattress ordered. She indicated the resident was to be turned and repositioned every two hours. She indicated CNAs found orders for turning and repositioning and specialty cushions in the profile section of the computer charting system and through verbal report from the nurses. During an interview on 1/26/16 at 2:58 p.m., the Director of Nursing (DON) indicated all residents in the facility were			

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	on a foam mattress as prevention for skin impairment. She indicated Resident #192 was to be repositioned every two hours while in wheelchair and in bed. She indicated they had attempted different cushions in the resident's wheelchair and a wedge pillow for the bed. She indicated the wound was unavoidable the second time it appeared due Resident #192 favoring the right hip. During an interview on 1/26/16 at 4:30 p.m., the DON indicated the facility did not use Braden scale, instead they used the admission screening for care plans to determine mobility and risk of pressure ulcers. The DON indicated they had not attempted a low air loss mattress for Resident #192, but indicated she believed it might be beneficial. During an interview on 1/27/16 at 11:32 a.m., CNA #33 indicated when a resident had an order to be turned and repositioned every two hours then she turned the resident from one side to the other in bed, and put pillows behind his/her if he/she was able to turn back over without assistance. She indicated she took care of Resident #192. She indicated she did not turn Resident #192 because she was always up in her wheelchair and she did not put her in bed. When asked specifically if she ever			

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	repositioned Resident #192, she indicated she did so every two hours by shifting the residents position from one side to the other. She indicated they did not chart when they repositioned or turned a resident. During an interview on 1/27/16 at 11:34 a.m., UM #30 indicated they had attempted multiple interventions to stop Resident #192 from favoring her right side. UM #30 indicated they had turned bed to other side to try to stop her from laying on right side since she preferred to face the wall when she was sleeping. UM #30 indicated the resident had been on a specialty foam mattress since her admission, and they had tried using a wedge pillow. She indicated Resident #192 was turned and repositioned in her chair and in bed every two hours. She indicated when a resident is repositioned they move the residents position from one side to the other to relieve pressure from an area, turn from one side to the other if in bed, and shift how direction the resident leans in chairs. UM #30 indicated after Resident #192's wound healed the first time they kept interventions of barrier cream and turn and repositioning every two hours in place. She indicated she was unsure how the wound had reopened. She indicated CNAs did not chart when residents were			

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	turned or repositioned. During an interview on 1/27/16 at 12:07 p.m., the ADON indicated when Resident #192's wound healed the staff continued to use barrier cream and continued to turn and reposition her every two hours. She indicated when a resident had an order to be turned and repositioned every two hours than she expected the staff to change the position of the resident in bed from one side to the other, and wanted them to shift the resident's position in the resident's chair when they were up. She indicated she was unsure why a new intervention was added on 10/1/15 to reposition Resident #192 in the bed and in the chair every 2 hours because the original intervention put in prior to any pressure ulcer to turn and reposition every two hours meant the same thing. During an interview on 1/27/16 at 12:33 p.m., the Minimum Data Set (MDS) Assistant #34 indicated their department usually created the standard care plans and nursing care plans. She indicated Resident #192 did not have any additional care plans, including discontinued plans, related to skin impairment or pressure. On 1/26/16 at 3:28 p.m., the DON provided the current policy titled, "Skin			

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	Management Program," dated 2/2015. The policy stated, "...Direct care givers will be notified of skin alterations and specific care needs...A plan of care will be initiated to include resident specific risk factors with appropriate interventions...Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place...Direct care givers will be notified of the resident's specific prevention interventions...Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes...The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported." 3.1-40(a)(2)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the	F 0323		02/27/2016

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	facility failed to ensure chemical were securely stored and hand rails were free of rough edges in 2 of 5 units reviewed for a safe living environment (Augustus Cottage 2 and Augusts Cottage 3). Findings include: 1. During an observation on 1/21/2016 at 11:43 a.m., in Augustus Cottage 3, the hand rail at the dinning/activity room entrance was missing a corner of the hand rail and the area was sharp and rough. The handrail located on the back hallway had a missing corner piece with exposed rough edges. During an interview on 01/27/2016 at 10:26 a.m., the Maintenance Director indicated the facility did not have a system for routine maintenance. He indicated he relied on staff to report concerns. He further indicated he had not been informed the hand rail located in the entrance hallway near the activity/dining room had a missing corner piece with exposed rough jagged edges. He indicated it was a concern and it needed repair. He further indicated the back hallway handrail had been repaired improperly and also had rough edges and needed repaired. 2. During an observation on 1/28/2016 at		It is the practice of this providerthat chemicals will be properly stored and hand rails will be free of roughedges I. What action has been taken for eachresident cited in the alleged deficiency? No residents were affected by thealleged deficient practice. The bottle storing chemicals was immediatelyremoved. II. How will the provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged deficient practice? All residents residing on memory care2 have the potential to be affected by this alleged deficient practice. Handrails were immediately fixed. Allunsecured rooms were immediately checked for chemicals. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? All staff will be in serviced on orbefore 2/23/16 by the DNS/Designee in regards to proper storage of chemicalsand use of maintenance requests. The Environmental Supervisor/designee willperform rounds every shift on memory care 2 to ensure that all chemicals areproperly stored.	

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	10:25 a.m., with Licensed Practical Nurse (LPN) present, the "Mop" closet door was observed open. The door was broken and would not close. Inside the room the following chemicals were observed: an unlabeled clear spray bottle which contained a green liquid, a bottle of "baseboard stripper," "Clorox Urine Remover," and "Acid D Lime. Material Safety Data Sheets, identified as current by the House Keeping Supervisor on 1/28/16 at 3:00 p.m., indicated Baseboard Stripper, Clorox Urine Remover, and Acid D Lime should be kept away from children, avoid contact with skin, and was dangerous if inhaled or ingested. During an interview on 1/27/16 at 11:00 a.m., the Executive Director indicated the facility did not have a routine maintenance policy. During an interview on 1/28/16 at 10:58 a.m., the Executive Director indicated the door to the "Mop" room on Augustus Cottage Two had been broken for approximately a month. He indicated chemicals were not supposed to be stored in the room. During an interview on 1/28/2016 at 10:50 a.m., the Maintenance Director		IV. To ensure compliance, theEnvironmental Supervisor will completethe Environmental Safety-Cottage audit tool weekly x 4weeks, Monthly x6 months, and thenquarterly until continued compliance is maintained for 2 consecutive quarters.The results of these audits will be reviewed by the CQI committee and overseenby the ED. If a threshold of 100% is not achieved an action plan will bedeveloped to ensure compliance. By what date the systemic changes willbe completed: 2/27/16	

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	indicated. He indicated he had just been informed the mop room door on Augustus Cottage Two was broken "a few days ago." During an interview on 1/28/2016 at 12:11 p.m., the House Keeping Supervisor indicated the mop room door located on Cottage Two had been broken for a "couple of months." She indicated chemicals were not supposed to be stored in the unsecured mop room. She indicated chemicals should not have been stored in unlabeled bottles. A "Safety" policy identified as current by the Executive Director on 1/28/16 at 12:00 p.m., indicated it was the facility's policy to ensure all chemicals were safely stored. 3.1-45(a)(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			

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	Based on observation, interview, and record review, the facility failed to ensure foods were labeled with open dates for 1 of 2 kitchen observations. This deficient practice had the potential to affect 132 of 132 residents who received food from the kitchen. Finding includes: During the initial kitchen observation on 1/20/16 from 10:36 a.m. to 10:48 a.m., with the Dietary Manager (DM) present, a large five gallon container of brown liquid and a large five gallon container of yellow liquid were observed in the walk-in cooler without labels stating the contents of the containers and the date made. During an interview on 1/20/16 at 10:43 a.m., the DM indicated the containers held ice tea and lemonade and were made the morning of 1/20/16. He indicated both containers should be labeled with the contents of the container and date made. On 1/26/16 at 3:28 p.m., the Director of Nursing provided the current policy titled, "Food Storage," dated 07/15. The policy stated, "...Leftover prepared foods are be to stored in covered containers or wrapped securely. The food must clearly	F 0371	It is the practice of this providerthat food will be labeled and dated upon opening. I. What action has been taken for eachresident cited in the alleged deficiency? Unlabeled food was immediately removedand discarded. No resident was affected by this alleged deficient practice II. How will the provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged deficient practice? All residents have the potential to beaffected by this alleged deficient practice. Dietary Manager immediatelyensured proper labeling and dating of all open items. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? Dietary staff will be in serviced onor before 2/23/16 by the Dietary Manager/designee in regards to proper labelingand dating of opened food items. The Dietary Manager/designee will auditkitchen refrigerator daily to ensure all items are labeled/dated appropriately. IV. To ensure compliance, the DietaryManager/designee will complete the Dating & Labeling of food CQI audit toolweekly x	02/27/2016

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	be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded...Refrigeration:...All foods should be covered or wrapped tightly, labeled and dated." 3.1-21(i)(3)		4weeks, Monthly x6 months, and then quarterly until continuedcompliance is maintained for 2 consecutive quarters. The results of theseaudits will be reviewed by the CQI committee and overseen by the ED. If athreshold of 100% is not achieved an action plan will be developed to ensurecompliance. By what date the systemic changes willbe completed: 2/27/2016	
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			

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	(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 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. Based on observation and interview, the facility failed to ensure residents' linens were transported in a sanitary manner. This deficient practice had the potential to affect 16 of 16 residents who resided on Augustus Cottage 3. Findings include: During an observation on 01/25/2016 at 12:51 p.m., the Laundry Supervisor was observed holding clean clothing protectors against her uniform in Augustus Cottage 3 dining area. During an interview on 01/28/2016 at 12:11 p.m., the Laundry Supervisor indicated clean linen should not be carried by a person, it should be pushed	F 0441	It is the practice of this Providerthat linens will be transported in a sanitary manner I. What action has been taken for eachresident cited in the alleged deficiency? No resident's wereadversely affected by this alleged deficient practice II. How will the Provider identifyother residents that may be affected by the same alleged deficient practice andwhat action taken to correct this alleged deficient practice? All residents have the potential to be affected. Laundry supervisor was immediatelyre-educated on proper handling of linen. III. What systemic changes will betaken to ensure the alleged deficient practice does not recur? All staff will be re-educated	02/27/2016

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	on a cart, and clean linen should not be carried next to a uniform. The "LAUNDRY/LINEN" policy was provided by the administrator on 1/28/16 at 11:00 a.m. This current policy indicated the following, "POLICY: The laundry staff shall handle, store, process, and transport, linen appropriately to prevent the spread of infection, in resident-care areas and in the laundry facility. PURPOSE: To ensure the proper care of linen to prevent the spread of infection. COMPONENTS... 2. Resident care areas: Clean Linen a. Clean linens should be carried away from the body to prevent contamination...." 3.1-19(g)(2)		byDNS/designee by 2/23/16 on proper handling of linen. All new hires will beeducated on proper infection control guidelines. The DNS/designee will perform rounds on allshifts to ensure linen is being handled appropriately. Any staff member witnessednot following facility policy will be immediately educated. IV. How the corrective actions will bemonitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place; and by what date the systemic changeswill be completed: Weekly" Infection-Control Review "CQI audits will be completed by DNS/designee weekly x 4, monthly x 3, then quarterlythereafter for at least 6 months and all data will be submitted and reviewed atthe monthly CQI team meetings. If the 100% threshold is not met, an action planwill be developed. By what date the systemic changes willbe completed: 2/27/2016	
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, interview, and	F 0465		02/27/2016

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	record review, the facility failed to ensure a functional and sanitary environment for 2 of 2 memory care units. This deficient practice had the potential to affect 37 of 37 residents who resided on the units. Findings include: During an initial environmental tour of Augustus Cottage 2 and 3 on 1/21/2016 at 11:18 a.m., the following was observed: a. Resident #41's bathroom (527) had two ceiling tiles with large brown stains, one ceiling tile was in disrepair exposing the pink insulation. The bathroom soap dispenser was in disrepair. b. Resident #73's chest of drawers was broken and in disrepair. c. Resident #60's room (530) had a privacy curtain with large circular brown stains across the bottom length of the curtain. The bathroom door had an oval shaped hole, the wall had a minimum of eleven areas which were covered with paint that did not match the paint color of the walls, a minimum of thirteen nail holes were noted on the walls, the hinge above the closet was missing two of the four screws and was separated from the wall. d. Resident #12's bathroom (535) had a ceiling tile that was torn and in disrepair.		It is the policy of this facility to ensurea functional and sanitary environment what corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice: No residents were adversely affectedby this alleged deficient practice How will other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken: All residents residing on memory care havethe potential of being affected by the alleged deficient practice. Allidentified environmental concerns to be corrected on or before 2/27/16. What measures will be put into placeor what systemic changes/ will be made to ensure that the deficient practicedoes not recur: All staff will be in-serviced on utilizing “MaintenanceRequest” slips to communicate any environmental issues by the DNS/designee onor before 2/23/16. Maintenance Supervisor/designee will review maintenancerequest slips daily and address any identified issues. How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality	

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	The closet door hinge was not securely attached to the wall and the door was not securely attached. e. the heater cover in Augustus Cottage Three's dining/activity room was not secured and loosely hung from the heater. There was a jagged edge and exposed equipment on top from a missing vent. f. outside of room 520 approximately three feet of base board was missing and the dry wall was peeling on the left side of the door. On the right side of the door an 1 X 1 foot area had been patched and left unpainted. g. on the back hall in Augustus Cottage Three near the exit door the base board was separated from the wall. The corner trim near the residents' bathroom was missing and had large dents noted in the wall. h. Resident #121's closet door had a screw pocking out where a door knob should have been. i. outside of room 506 the base board was missing, there was peeled drywall near the door sign. j. above the exit door by room 506 there was a hole in the wall exposing wires. k. near the entrance to Augustus Cottage Three's dining/activity room drywall was peeling from the handrail down to the floor. The dining/activity room floor had had areas where the linoleum was missing and multiple areas with deep		assuranceprogram will be put into place :Environmental Safety-Cottage will be utilizedevery week x 4, Monthly x 3, and every other month x3 for at least 6 months. Datawill be collected by DNS/Designee and submitted to the CQI Committee. If the thresholdof 95% is not met, an action plan will be developed. By what date the systemic changes willbe completed: 2/27/16	

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	scratches. which extended across eight 1 foot X 1 foot tiles. l. Resident #151's room (514) was observed on 1/25/16 at 9:32 a.m. Her closet door was off the track and dangling loose. The bathroom vanity doors had and a piece of wood screwed into the doors to prevent them from opening and they were loose and crooked. Calking around a toilet was black and loose. Her chest of drawers was missing a drawer. m. the blinds in Resident #93's room (528) were in disrepair. During an observation on 1/28/2016 at 10:25 a.m., with Licensed Practical Nurse (LPN) #104 and the memory care Activity Director present, the residents' bathroom located on Augustus Cottage Two was observed. Six of the 2 x 4 ceiling tiles were missing exposing wires and pipes, a steady drip of water was observed leaking from the bathroom sink into a gray wash basin, the flooring had a two foot by one foot tear exposing the sub floor. During an environmental tour and interview on 01/27/2016 at 10:26 a.m., the Maintenance Director indicated he was not aware of the environmental concerns on the Cottages. He indicated the hole over the exit door with wires going into it may be a life safety code			

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	problem and would be fixed right away. He further indicated base boards, activity/dining room floor, the dry wall, residents' closet doors and bathroom vanities, holes in the wall, the heater cover, all were in disrepair and were not currently scheduled to be repaired. He indicated there were too many requests and it was "hard to keep up" with the demand. He also indicated they did not do regular maintenance tours to look for problems but rather waited on staff to report concerns. During an interview on 1/27/16 at 10:45, with Housekeeper #15 and Qualified Medication Aide (QMA) #16 present, Housekeeper #15 indicated if she had a maintenance or housekeeping request she would put in writing on a maintenance form or tell her supervisor. She indicated she felt maintenance just "couldn't keep up." QMA #16 indicated if she had a maintenance issue she would fill out a maintenance form. During an environmental tour and interview on 1/28/2016 at 9:45 a.m., with the Executive Director present, the Executive Director indicated he was aware of the maintenance repairs needed on the Cottages. He indicated he would make plans to repair the blinds in disrepair, the nail holes, the patchy paint			

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	work, the broken hinges, the holes in the doors, the ceiling tiles in disrepair, the floors, and other environmental needs. During an interview on 1/28/16 at 10:30 a.m., with Certified Nursing Assistants (CNA) #102 and CNA # 103, CNA #103 indicated Augustus Cottage Two's bathroom was utilized to toilet and change residents. CNA # 102 indicated the sink had been leaking for about a month. During an interview on 1/28/2016 at 10:50 a.m., the Maintenance Director indicated Augustus Cottage Two's bathroom ceiling tiles were removed two weeks ago to repair a leak and had not been replaced. He indicated he had not been informed the bathroom sink had been leaking. He indicated he had just been informed the mop room door was broken "a few days ago." During an interview on 1/28/2016 at 12:11 p.m., the House Keeping Supervisor indicated the facility didn't have enough privacy curtains to routinely wash them. She indicated the mop room door had been broken for a couple of months. During an interview on 1/28/2016 at 12:15 p.m., the Executive Director			

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	indicated the facility did not have a policy for routine maintenance. 3.1-19(f)			
F 0520 SS=E Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation,interview and record review, the facility failed to ensure a process for quality improvement to	F 0520	It is the policy of this facility tomeet for a quality assessment and assurance committee monthly to identifyissues &	02/27/2016

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	ensure residents were provided meaningful activities, emerging pressure ulcers were identified and interventions were implemented to prevent or facilitate healing of pressure ulcers, and the environment was maintained in a functional, sanitary condition. This deficient practice had the potential to affect 137 of 137 residents residing in the facility. Findings include: 1. During observations on 1/20//16 at 12:19 p.m. and 12:42 p.m., on 1/21/16 at 9:35 a.m., and 2:52 p.m., on 1/25/16 at 9:30 a.m., 10:30 a.m., 12:00 p.m., 1:30 p.m., and 2:30 p.m., and on 1/26/16 at 9:20 a.m. and 10:00 a.m., Resident #114 was not participating in meaningful activities per the activity calendar or care plan. Resident #114's record was reviewed on 1/22/16 at 3:00 p.m. An activity care plan, dated 10/23/15, indicated Resident #114 required reminders to attend group activities of interest. A goal indicated she would enjoy group activities of interest to her level of satisfaction through the next assessment date. Approaches indicated the facility would invite her to games, provide her with the assistance needed, remind her of bingo and socials, and		develop and implement appropriate plans of correction. what corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice: Residents were provided meaningfulactivities: Resident # 114 and # 91's activity care plans/preferences werereviewed and updated. Emerging pressure ulceridentification: Resident # 110 received treatment orders for new skin areas.Resident #110's care plan and resident profile was updated to reflect currentplan of care and changes. Environment: No resident's wereaffected by this alleged deficient practice How will other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken: Residents were provided meaningfulactivities: All residents on memory care unit have the potential of being affectedby the alleged deficient practice. All activity care plans for residentsresiding on memory care unit will be reviewed and updated to reflect currentpreferences on or before 2/23/16 Emerging pressure ulceridentification: All residents have thepotential of being affected by the alleged deficient	

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	respect her right to choose activities. An activity attendance document for January 1-26, 2016, was reviewed on 1/26/16 at 11:30 a.m. This document indicated Resident #114 did not attend activities on 13 out of 26 days on January 5, 7, 8, 10, 11, 12, 14, 16, 17, 18, 19, 22, and 26, 2016, and only participated in one activity titled "Daily Chores" on ten additional days January 1, 2, 3, 4, 9, 14, 20, 23, 24, and 25, 2016. The document indicated, "Needs independent tracking everyday if she's not coming to activities." During observations on 1/20/16 at 12:19 p.m., 1/21/16 at 9:35 a.m., 9:43 a.m., and 2:53 p.m., 1/25/16 at 9:30 a.m., 10:30 a.m., 12:00 p.m., 1:30 p.m., and 2:30 p.m., and 1/26/16 at 9:20 a.m., and 10:00 a.m., Resident #108 was not participating in meaningful activities per the activity calendar or care plan. Resident #108's record was reviewed on 1/25/16 at 2:56 p.m. An activity care plan, dated 12/23/15, indicated Resident #108 enjoyed snack time, cooking, bingo, and pet visits. A goal indicated she would attend at least two activities a day. Approaches indicated staff was to invite and encourage her to attend activities.		practice. Skin sweeps will be conducted on allresidents by the Director of Nursing/designee by 2/23/16. If a new area isidentified, MD will be notified and a new treatment order will be obtained. Environment: All residents residing onmemory care have the potential to be affected by the alleged deficientpractice. What measures will be put into placeor what systemic changes/ will be made to ensure that the deficient practicedoes not recur; Facility will utilize CQI tools called, “Wound-Skin CQI”, “Cottage Activities”, and“EnvironmentalSafety-Cottag e” monthly in the CQI monthly process. All nursing staff will bein-serviced on reporting new skin issues and pressure ulcer prevention by theDirector of Nursing/designee on or before 2/92/16. All memory care activitiesstaff will be in-serviced on following resident specific activities as per planof care by the MCF/designee on or before 2/23/16. How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place CQI monitoring tools called Wound-Skin CQI,Cottage Activities, and Environmental	

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	An activity attendance document for November 1, 2016 through January 26, 2016, was reviewed on 1/26/16 at 11:30 a.m. The document indicated Resident #108 was provided one or fewer activities on twenty out of thirty days in November on 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 21, 22, 24, 25, 29, and 30, fourteen out of thirty-one days in December on 12/3, 5, 6, 7, 8, 12, 13, 17, 18, 21, 23, 25, 27, and 31, and five out of twenty-six days in January on 1/2, 8, 9, 15, 20. During observation on 1/25/16 at 10:38 a.m., 10:42 a.m., and 11:48 a.m., 1/25/16 at 11:00 a.m., 12:07 p.m.,1:25 p.m., 1:53 p.m., and 2:30 p.m., Resident #91 was not observed participating in facility activities per the calendar or care plan. An activity care plan, dated 12/28/15, indicated Resident #91 had Alzheimer's disease as well as other health problems, which could impact her desire to participate in group activities. The plan indicated Resident #91 was provided with one on one activities. A goal indicated "with encouragement, cues, and reminders" she would participate in group activities of interest through the next assessment date. Approaches indicated the facility would encourage and assist her with sewing and crocheting		Safety- Cottage will be utilized every weekx 4, Monthly x 3, and every other month x3 for at least 6 months. Data will becollected by DNS/Designee and submitted to the CQI Committee. If the thresholdof 95% is not met, an action plan will be developed. By what date the systemic changes willbe completed: 2/27/16	

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	as needed, encourage daily socialization outside of her room, encourage family visits, encourage participation in scheduled programming, and respect her right to choose activities. In addition, a one on one activity care plan, dated 1/21/16, indicated Resident #91 would be provided 2-3 one to one activities per week beginning 1/21/16. Resident #91's record was reviewed on 1/25/16 at 3:23 p.m. An activity attendance document for November 1, 2016 through January 26, 2016, was reviewed on 1/26/16 at 11:30 a.m. The document indicated Resident #91 was provided one or fewer activities on twenty-six out of thirty days in November on 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, and 30, twenty-nine out of thirty-one days in December on 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, and 31., and twenty-two out of twenty-six days in January on 1/1, 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26. The record indicated she was provided a one on one activity on 1/21/16 for 15 minutes and 1/22/16 for 30 minutes. An Activity Policy, identified as current			

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	on 1/26/16 at 3:31 p.m., indicated, "...The activity department will develop a calendar of activities that reflects the needs and interest of the residents...any changes to the calendar will be posted on the calendar... It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...." 2. Resident #110's record was reviewed on 1/22/2016 at 12:20 p.m. A "Pressure Wound Skin Evaluation Report," dated 1/19/16, indicated Resident #110 had an unstageable pressure ulcer with necrotic/eschar tissue to the right heel with measurements of 5.5 cm (centimeters) x 6 cm x 0.1 cm. The report indicated Resident #110 also had an unstageable pressure ulcer with necrotic/eschar (dry, dark scab or falling away of dead skin) tissue to the left heel with measurements of 4 cm x 2.3 cm x 0.1 cm. The record indicated Resident #110 had diagnoses which included, but were not limited to, osteoporosis, peripheral vascular disease, neuropathy, chronic kidney disease, type 2 DM, and pressure ulcers. The record indicated Resident #110 had developed a stage 3 pressure ulcer to his left buttocks within			

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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
	30 days of admission to the facility that had a current status of healed. The record lacked indication protein levels and/or albumin levels had been obtained since the resident's admission. The record lacked indication Resident #110 refused interventions to prevent or promote healing of pressure ulcers. During an observation of incontinence care on 1/27/2016 from 12:01 p.m. an open area was observed as a stage 2 pressure ulcer to both Resident #110's right and left buttock. RN #63 indicated he was unaware of the pressure ulcers before the incontinence care. On 1/26/16 at 3:28 p.m., the DON provided the current policy titled, "Skin Management Program," dated 2/2015. The policy stated, "...Direct care givers will be notified of skin alterations and specific care needs...A plan of care will be initiated to include resident specific risk factors with appropriate interventions...Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place...Direct care givers will be notified of the resident's specific prevention interventions...Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment,			

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	155620	A. BUILDING 00 B. WING	01/28/2016

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	to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes...The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported." 3. During an environmental tour of Augustus Cottage 2 and 3 on 1/21/2016 at 11:18 a.m., resident environments sues included, but were not limited to, blinds in disrepair, nail holes and patchy paint work, broken hinges, holes in doors and ceiling tiles in disrepair. During an environmental tour and interview on 1/28/2016 at 9:45 a.m., with the Executive Director present, the Executive Director indicated he was aware of the maintenance repairs needed on the Cottages. He indicated he would make plans to repair the blinds in disrepair, the nail holes, the patchy paint work, the broken hinges, the holes in the doors, the ceiling tiles in disrepair, the floors, and other environmental needs. During an interview on 01/28/2016 at 10:07 a.m., the Administrator indicated the Quality Assessment and Assurance (QAA) meetings were held routinely, and issues identified by the home office were reviewed. He indicated these issues were on a "calendar" provided by the home			

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	office. Pressure was indicated on the calendar, not because they had identified facility concerns, but because it was required by the home office to be reviewed three times a year. He indicated pressure concerns were scheduled for review in February 2016. He indicated if any concerns were identified outside of the calendar they would review them in the next QAA meeting. He also indicated they have a process to follow up with the concerns, look for trends, set a goal, and reevaluate. He indicated concerns with activities and/or the environment had not been identified and/or addressed during QAA process. He further indicated pressure ulcers, environment, and activities had not been identified as an area of concern by the facility. 3.1-52(b)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 41 Sample: 10	R 0000	Dear Kim Rhoades, This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post-survey review on or after	

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	This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5. Quality review completed 2/3/16 by 29479.		2/27/2016. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure foods were labeled with open dates for 1 of 2 kitchen observations. This deficient practice had the potential to affect 41 of 41 residents who received food from the kitchen. Finding includes: During the initial kitchen observation on 1/20/16 from 10:36 a.m. to 10:48 a.m., with the Dietary Manager (DM) present, a large five gallon container of brown liquid and a large five gallon container of yellow liquid were observed in the walk-in cooler without labels stating the	R 0273	**It is the practice of this facility to ensure that all food preparation and serving areas are maintained in accordance with the state and local sanitation and food handling standards. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Unlabeled beverages were immediately removed and discarded. No resident was affected by this alleged deficient practice. All Food Service staff will be in-serviced on or before 2/27/16 on proper dating and labeling of all opened food and/or beverages. **How will you identify other residents having the potential to be affected by**	02/27/2016

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	contents of the containers and the date made. During an interview on 1/20/16 at 10:43 a.m., the DM indicated the containers held ice tea and lemonade and were made the morning of 1/20/16. He indicated both containers should be labeled with the contents of the container and date made. On 1/26/16 at 3:28 p.m., the Director of Nursing provided the current policy titled, "Food Storage," dated 07/15. The policy stated, "...Leftover prepared foods are be to stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded...Refrigeration:...All foods should be covered or wrapped tightly, labeled and dated." 3.1-21(i)(3)		**the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice. Dietary Manager immediately ensured proper labeling and dating of all open items. The Dietary Manager/Designee will round the facility on an on-going basis and will check all food storage areas for unlabeled and/or undated food or beverages. The facility will in-service all dietary staff on proper food storage and proper labeling/dating on or before 2/27/16. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur:** The Dietary Manager/Designee will round the facility on an on-going basis and will check food storage areas for unlabeled and/or undated food or beverages. The facility will in-service all dietary staff on proper food storage and proper labeling/dating on or before 2/27/16. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The following CQI monitoring tools, Labeling and Dating Food will be completed weekly x 4 weeks, then monthly x 3 months, and quarterly thereafter for at least 6 months and discussed with IDT. Data will be collected by	

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			the Dietary Manager and submitted to the General Manager. If the threshold of 100% is not met, an action plan will be developed. Non-compliance with the facility procedure may result in disciplinary action up to and including termination.	