STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	12/05/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00213797. Complaint IN00213797 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey dates: November 28, 29, 30 & December 1 & 2, 2016. Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census bed type: SNF/NF: 61 Total: 61 Census Payor type: Medicare: 16 Medicaid: 44 Other: 1 Total: 61 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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F 0156 SS=C Bldg. 00	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as			

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	the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and			

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	Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency			

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	concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the			

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	nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the			

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	resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.			
	Based on record review and interview, the facility failed to ensure 3 of 3 residents received information regarding their discharge from Medicare services. (Resident #10, #45 and #72) Finding includes: On 11/28/16 at 2:35 P.M., the OMB (Office of Management and Budget) Approval No. 0938-0953 form entitled "Aperion Care Peru - Notice of Medicare Non-Coverage (NOMNC)" was reviewed for Resident #10, Resident #45 and Resident #72. The forms indicated "...Please sign below to indicate you received and understood this notice...I have been notified that coverage of my services will end on the effective dated indicated on this notice and that I may	F 0156	**F156** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	01/04/2017

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	appeal this decision by contacting my AIO [Quality Improvement Organization]...." The NOMNC for Resident #10 indicated "...Notified [name of Resident's POA] of patients d/c [discharge] from skilled services and change in payer on 10/31/16, POA [Power of Attorney] to sign notification upon next visit to facility...." There was no signature from POA or resident signifying the information on the notice was received. The NOMNC for Resident #45 indicated " ...Patient notified of d/c [discharge] from skilled service and change in payer on 8/1/16, patient refused to sign notification...." There was no indication the resident had received the appeal information. The NOMNC for Resident #72 indicated "...Patient and family notified of d/c [discharge] from skilled services and return to prior living arrangements on 9/23/16...." There was no signature on the form. On 11/29/16 at 1:00 P.M., the Administrator provided a policy titled, "Form Instructions - Advanced Beneficiary Notice on Non-Coverage (ABN) - OMG [not defined] Approval		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #45, Due to the time requirements of obtaining signatures on NOMC-Notice of Medicare Non-Coverage documents no signature could be requested. Resident #10, No longer resides in this facility. Resident #72, No longer resides in this facility. **2) How the facility identified other residents:** All residents receiving Medicare A covered services have the potential to be affected. Those residents currently on Medicare A services have been identified and their remaining days of coverage have been reviewed. There are no residents reaching exhaustion of services in the next 7 days. No NOMC need issued at this time.	

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	Number 0938-0566, undated, and indicated the policy was the one currently used by the facility, regarding Notice of Medicare Non-Coverage. The policy indicated "...E Signature Box...Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the notice...." During an interview, on 11/30/16 at 9:20 A.M., the Administrator indicated the Business Office Manager was unaware the resident or the resident's representative's signature needed to be on the form to indicate they had received the information included on the form, such as the date services would be end and appeal rights information. The administrator could not confirm or deny all information was discussed when resident or resident's representative was notified. The Business Office Manager was not available for an interview. 3.1-4(f)(3)		**3) Measures put into place/ System changes:** Social Services will be responsible for obtaining resident/POA signatures on the NOMC. The Social Service Director has been given in-service training on the guidelines of issuing the NOMC. All resident receiving Medicare A services will be reviewed weekly and remaining days of coverage will be identified. The Social Service Director will notify any resident/POA of upcoming exhaustion within a 7 day window by issuing letter and appeal notice for signature. The signed notice will be maintained by the facility and a copy will be given to the resident/POA. If resident/POA is unable to sign or refuses, the SSD will make note of the reason with the date and a copy of the notice will still be issued. If documentation must be mailed for signature, the SSD will note the date the notice was mailed and who it was mailed to. If the copy is not received back in a timely manner, the SSD will attempt to reach receiving party to verify they received the notice. The SSD will make note of that attempt.	

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			The Interdisciplinary team will review discharges weekly to ensure notices have been issued. **4) How the corrective actions will be monitored:** The Administrator or designee will audit the notices issued weekly to ensure proper steps were taken in obtaining signatures and notifications. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **1-4-2017**	
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES			

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	(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on observation, interview and record review, the facility failed to ensure 2 of 35 residents received a shower according to their preferences (Resident #27 and #15). Findings include: 1. During an interview on 11/29/16 at 10:16 A.M., Resident #27 indicated she received sponge baths but, would prefer to take a shower. She indicated she had let staff know she would prefer a shower and the staff indicated that sponge baths are all they have available. During an observation on 11/29/16 at 10:16 A.M., the resident's hair was greasy and uncombed. During an interview on 12/2/16 9:59 A.M., Resident #27 indicated she still	F 0242	**F 242** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident #27 resident choice assessment reviewed and 1st choice of shower was indicated	01/04/2017

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	only received sponge baths because there were "no bathing facilities here." A quarterly, 11/15/16, MDS (Minimum Data Set) assessment indicated the resident was cognitively intact and required physical help in part of bathing activity from staff. A current, 10/11/16, care plan focus for the resident was potential for an ADL (Activities of Daily Living) self care performance deficit. Interventions included but, were not limited to, "... [Name of Resident] prefers showers 2 times a week or every other day in the evening... BATHING: The resident requires extensive (1) staff participation with bathing...." An "Activities-Preferences Interview" report, dated 10/27/16, indicated the resident preferred showers or tub baths. On 12/2/16 at 12:50 P.M., the DON (Director of Nursing) provided the policy titled "Bath/Shower Schedule," dated 9/1/16, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: A tub bath, complete bed bath or shower will be given to each resident by a Certified Nurse Assistant two times per week as scheduled/prn [as needed] unless		and preference placed on the resident care plan and kardex. The shower schedule has been updated. 2. Resident #15 resident choice assessment was reviewed and 1st choice of shower was place placed on the residents care plan and kardex for 2 times a week. **2) How the facility identified other resident:** Resident choice preference assessment have been reviewed on all resident in the facility and care plans and kardexs have been updated. **3) Measures put into place/systems changes:** Nursing staff was re-educated on resident choice/preference on showers/bathing schedules and shifts. Information will be located on the resident Kardex. **4) How the corrective actions will be monitored:**	

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	otherwise requested by the resident... 1. Charge Nurse makes an assignment sheet to include baths or showers that are scheduled for that respective date and shift... 3. Certified Nurse Assistants give bath or shower as scheduled. 4. If resident refuses bath or shower, the Charge Nurse is notified for intervention and follow up...." 2. During an interview on 11/29/2016 at 11:04 A.M., Resident #15 indicated she had not had a shower in a week. She indicated she had not had a shower in a week. She indicated she did not always get her showers as scheduled. During an interview on 12/01/2016 at 10:04 A.M., LPN (Licensed Practical Nurse) #51 indicated that resident showers were scheduled for Wednesday and Saturday morning. She indicated she can't recall if resident had refused lately. During an interview on 12/01/2016 at 10:10 A.M., Resident #15 indicated she was never offered a shower on Wednesday or on Saturday. She further indicated she doesn't believe she should have to run around and ask for her showers and that when she doesn't receive a shower, she feels "lousy". During an interview on 12/01/2016 at		The Director of Nursing or designee will audit 10 resident bathing records per week on varied units and shifts to ensure bathing is provided according to preference and care plan x30 days, then 5 bathing records per week on varied units and shifts until 100% compliance is achieved x3 consecutive months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **Date of compliance: 1-4-17**	

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	10:15 A.M., CNA (Certified Nursing Assistant) # 50 indicated shower list by nursing station reflected Resident #15 showers were on Wednesday and Saturday day shift. During an interview on 12/01/2016 at 12:33 P.M., DON (Director of Nursing) indicated showers are documented on POC (plan of care) documentation and showers refused would show up in documentation. She indicated staff should ask at least three times and the CNAs are to let nurses know of any refusals. Resident #15 clinical record was reviewed on 12/2/2016 at 2:00 P.M. The resident's diagnoses included, but were not limited to major depressive disorder, Parkinson's Disease, and dysarthria. The resident's annual Minimum Data Set (MDS) assessment, dated 9/14/2016, indicated resident requires extensive assistance with 2 person assist and indicated the Basic Interview Mental Status (BIMS) score was 13 with a score of 8 to 15 as interviewable. The look back report from Point of Care indicated Resident #15 had received showers on 11/2/2016, 11/5/2016, 11/9/2016, 11/19/2016, and 11/23/2016.			

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	During an interview on 12/2/2016 at 3:30 P.M., DON indicated that 6 showers in 30 days was not acceptable. 3.1-3(u)(1) 3.1-3(u)(3)			
F 0257 SS=D Bldg. 00	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. Based on observation and interview, the facility failed to ensure a room temperature was comfortable for 1 of 35 residents reviewed for comfortable temperatures (Resident #27). Finding includes: On 12/2/16 at 9:58 A.M., Resident #27 was observed in her bed with blankets covering her. During an interview on 12/2/16 at 9:59 A.M., the resident indicated she was cold. During an environmental observation on 12/2/16 at 10:14 A.M., the maintenance	F 0257	**F 257** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.*	01/04/2017

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	155702	A. BUILDING 00 B. WING	12/05/2016

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APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	supervisor used an air temperature gauge and indicated the temperature in the resident's room was 69.5 degrees. He indicated the heater in the room was turned off. During an interview on 12/2/16 at 10:15 A.M., the resident stated, "No wonder it was so damn cold in here," and indicated she had let staff know know she was cold but, nothing was done. During an interview on 12/2/16 at 1:43 P.M., the Maintenance Supervisor indicated the acceptable room temperature range was 71- 81 degrees. No further information was provided before exiting on 12/2/16. 3.1-19(h)		**1) Immediate actions taken for those residents identified:** Immediate monitoring and adjustment of the Heating system and temperature was brought back within acceptable parameters. **2) How the facility identified other residents potentially affected:** Temperatures were taken in all resident rooms and common areas with no negative findings. **3) Measures put into place/systems changes:** Preventative maintenance will be completed quarterly on the Heating system. Staff will be in-serviced on reporting resident complaints about temperature within rooms or common areas to the Administrator or Maintenance department for follow up. **4) How the corrective actions will be monitored:**	

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			Maintenance will take ambient temperatures in various resident rooms and common areas throughout the facility at varied times at least 5x/ week x30 days, then weekly thereafter until 100% compliance is achieved x3 consecutive months. The Administrator is responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of Compliance:** 1-4-17	
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure	F 0282	**F282**	01/04/2017

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	physician's orders were followed for a resident's dressing change (Resident #40 and Resident #71), for obtaining blood pressure reading before giving a blood pressure medication (Resident #59), following interventions to prevent a fall (Resident #66) and following interventions for bathing preferences. (Resident #48) Findings include: 1. Resident #40's record was reviewed on 11/30/16 at 1:35 P.M.. Diagnoses included, but were not limited to, dementia, muscle weakness, muscle wasting and atrophy, cardiomegaly, diabetes and hypertension. The resident's Quarterly MDS (Minimum Data Set) assessment, dated 10/13/16, indicated she had a severe cognitive impairment, required extensive assistance from staff for personal hygiene, bed mobility and transfers and was at risk for developing pressure ulcers. The resident had a current, 11/16/16, care plan focus of a current pressure ulcer on her coccyx. Interventions included, "...Monitor/document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, document progress in wound		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #40, this resident no longer resides in our facility. Resident #71, treatment orders, care plans have been reviewed and physician notified. Resident #59, the physician has been notified of blood pressure outside of parameters and medication given with no negative outcomes. Resident #66, care plans, interventions have been reviewed and updates made to Kardex to indicated high fall risk. Resident #48 bathing preferences have been reviewed, scheduled &	

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	healing on an ongoing basis. Notify physician as indicated... Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of infection: Green drainage, Foul odor, Redness and swelling, Red lines coming from the wound, Excessive pain, Fever... Treatment as ordered... Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations...." A progress note, dated 11/14/16, indicated, "...Skin concerns observed: Coccyx - 3.0 [length]x1.5 [width] x0.2 [depth] [centimeters]. previous [sic] Pressure area in coccyx area, reopened. Defined borders. 100% granulation present. Tissue presents as beefy red. Surrounding skin intact. Moderate disc [discomfort] noted upon assessment. 0 [zero] drng [drainage] noted. Tx [treatment] cont [continued] per orders...." A "Skin-Pressure/Diabetic/Venous/Arterial Wound Report," dated 11/14/16, indicated, the wound was unstageable (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed		Kardex updated. **2) How the facility identified other residents potentially affected:** All resident's identified as to having pressure/skin concerns have has their treatment orders reviewed and updated as needed. All residents identified with parameters on Anti-Hypertensive medication have been reviewed. Falls have been reviewed from past 30 days with interventions updated and place on care plans and kardex. Resident choice preference assessment have been reviewed on all resident in the facility and care plans and kardexs have been updated. **3) Measures put into place/systems changes:**	

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	because it is obscured by slough or eschar) and the treatment ordered was, "...wound cleanse. pat dry. apply xeroform and bordered foam. BID [twice a day]. may replace if becomes soiled or dislodgement occurs...." Review of the resident's physician's orders indicated the dressing change treatment was started on 11/15/16, put on hold on 11/18/16 and discontinued on 11/22/16. A progress note, dated 11/18/16, indicated, "...WN [wound nurse] assessed res [resident]. [Doctor's Name] notified of bowel secreting from vaginal area along with fecal matter from rectum. Discussion of res hx [history]. [Doctor's Name] requested res be sent to [Name of Hospital]... for further examination...." An "Admission/Readmission Observation," report, dated 11/22/16, indicated the resident had an "unstageable pressure area noted. 2.7x1.5xNM [not measured]... Details/comments unstageable pressure area noted on coccyx... Wound is 100% slough upon return from hospital. Tx orders to cont [continue]. Monitoring cont by wound nurse daily. MD [medical doctor] aware...."		Nursing staff were re-educated on New/Re-admission skin assessment, documentation, identifying high risk medications and observing parameters, and initiating orders. Nursing staff were re-educated on fall interventions and the fall program in place. Nursing staff were re-educated on the bathing/shower schedule, how to identify what day to give. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will review wound treatment orders during clinical meeting on 3 residents per week. The Director of Nursing or designee will audit antihypertensive medications in clinical meeting 5 days a week to ensure compliance. The Director of Nursing or designee will observe 10 residents per week during rounds on varied shifts x30 days, then 5	

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	A "72 HR Admission/Readmission Charting" report, dated 11/22/16, indicated, "...Skin/Wound... Notable change in current wound/skin condition...." A "72 HR Admission/Readmission Charting" report, dated 11/23/16, indicated, "...Skin/Wound... Wounds/skin concerns present with no changes in skin integrity...." A "72 HR Admission/Readmission Charting" report, dated 11/24/16, indicated, "...Skin/Wound... Wounds/skin concerns present with no changes in skin integrity...." A "72 HR Admission/Readmission Charting" report, dated 11/25/16, indicated, "...Skin/Wound... Wounds/skin concerns present with no changes in skin integrity...." Review of the resident's Treatment Administration Record for November 2016 indicated she had the dressing changed once on 11/15/16, twice on 11/16/16, once on 11/17/16 and once on 11/18/16. The record indicated she was in the hospital for the 8:00 P.M. change on 11/18/16 through the 8:00 A.M. change on 11/22/16, when the order was discontinued.		residents per week to ensure fall interventions are in place according to plan of care. The Director of Nursing or designee will interview 3 resident's per week to ensure shower preferences are followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1-4-17**	

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	During an interview on 11/30/16 at 3:56 P.M., the Director of Nursing indicated the wound nurse had been working on the floor and had not seen or assessed Resident #40's pressure area this week. She indicated most of the time, the wound nurse did the dressing changes but, because she had been working the floor, the night shift nurse had been doing it. She indicated there was no way to tell in the computer or on the TAR (Treatment Administration Record) that the dressing change was being done because the order had been omitted when Resident #40 was re-admitted to the facility. She indicated the order was for twice daily before the resident was hospitalized and, upon return from the hospital, was only being done once a day. She indicated there were no measurements or assessments documented of the wound after 11/22/16 when she was re-admitted to the facility. During an interview on 11/30/16 at 4:44 P.M., LPN #13 indicated she was the wound nurse and she usually did rounds with the wound doctor on Mondays. She indicated the wound doctor was supposed to see the resident but, she was hospitalized when he came in last and was out sick this week. She indicated she had assessed the resident's wound on			

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	11/27/16 but, because she had been working the floor, she had not documented the assessment. She indicated she did not see the wound daily. She indicated when the resident was re-admitted on 11/22/16 she spoke to the nurse on duty and verbally confirmed the dressing order but, did not check to see that the order was put in. She indicated she spoke to the wound doctor after the resident was re-admitted and he verbally confirmed the Xeroform order was to continue twice daily. She indicated the dressing change was being done daily on night shifts but that it was not documented anywhere. During an observation on 11/30/16 at 5:00 P.M., the resident's wound did not have any signs or symptoms of infection and LPN #13 indicated the measurements taken were smaller than the previous measurements. During an interview on 12/1/16 at 10:29 A.M., LPN #10 indicated the wound nurse usually did the dressing change for the resident. She indicated she was unsure of when the dressing change was being done but, knew it was being done. She indicated she would not do a dressing change if it was not on the TAR. She indicated she did not know how other nurses knew to do the dressing			

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	change since it was not in the TAR. 2. Resident #59's clinical record was reviewed on 11/30/16 at 8:36 A.M.. Diagnoses included but, were not limited to, hypertension and dementia. The quarterly, 11/1/16, MDS (Minimum Data Set) assessment indicated Resident #59 was severely cognitively impaired. The resident's physician's orders included, but was not limited to, "...Metoprolol Tartrate Tablet [a blood pressure medication] 25 MG [milligrams] Give 1 tablet by mouth two times a day for CAD [coronary artery disease] hold for SBP [systolic blood pressure] < [less than] 110 and HR [heart rate] < 60...." The MAR (Medication Administration Record) for the resident was reviewed and indicated no blood pressure reading was obtained prior to the administration of the Metoprolol for the months of October and November 2016. It indicated he received the Metoprolol twice a day, every day, with the exception of 10/28/16 at 8:00 A.M. which was blank. The "Weights and Vitals Summary" report, dated 10/1/16 through 12/1/16 indicated the following blood pressure			

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	readings: 10/8/16 at 5:10 A.M., 92/42 10/14/16 at 5:52 A.M., 108/58 10/27/16 at 10:20 P.M., 98/66 10/28/16 at 10:05 P.M., 90/44 10/30/16 at 3:00 P.M., 102/68 11/1/16 at 2:10 P.M., 102/76 11/2/16 at 1:03 P.M., 100/64 11/18/16 at 12:45 A.M., 104/66 The "Weights and Vitals Summary" report, dated 10/1/16 through 12/1/16 indicated the following blood pressure readings: 10/8/16 at 5:10 A.M., 54 bpm (beats per minute) 10/14/16 at 7:53 A.M., 58 bpm During an interview on 12/2/16 at 2:43 P.M., the DON (Director of Nursing) indicated a blood pressure reading should have been obtained prior to the administration of the Metoprolol. On 12/2/16 at 2:43 P.M., the DON provided the policy titled "MEDICATION ADMINISTRATION," dated 6/2014, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Procedure... j. Obtain and record any vital signs as necessary prior to medication			

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	administration... 10. If the physician order cannot be followed for any reason, the physician should be notified in a timely manner... and a note should reflect the situation in the resident chart...." 3. During an observation on 11/30/2016 at 5:24 P.M., the WN (Wound Nurse) removed the foam dressing dated 11/30 from the sacral region of Resident #71. Pale yellow slough was observed in the base of wound the size of a nickel. The WN indicated wound measurement was 2.0cm (centimeters) x 1.4cm x 0.7cm. She described the base of wound as 90% slough and 10% epithelial tissue and indicated current stage III wound was now unstageable wound. During an interview on 11/30/2016 at 5:30 P.M., the Wound Nurse indicated the current dressing was collagen covered with foam to be changed every other day, and she indicated collagen was not present in the wound dressing during observation of dressing removal and measurement. Wound nurse indicated wound measurement completed on 11/28 are not available. She indicated measurements from 10/18/16 to 11/7/16 were not completed. She indicated she used the measurements from the wound doctor and did not measure the wounds herself.			

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	During an interview on 12/01/2016 at 2:16 P.M., WN indicated that wound measurements from left and right buttocks observed on 10/18/16 were not completed, she indicated wound physician incorporated all wound measurements together. She indicated she used the measurements from the physician for facility wound log and skin reports. During an interview on 12/01/2016 at 2:50 P.M., the DON (Director of Nursing) indicated the wound nurse has not had any wound education other than a one day wound seminar attended in late October. She indicated there was not a job description for wound nurse in employee's file. She indicated that wound measurements should be completed every seven days and physician orders are to be followed in regards to treatments. During an interview on 12/2/2016 at 10:00 A.M., the DON indicated Resident #71 had two different orders. Santyl was ordered daily at 6:00 A.M. and collagen covered with foam was ordered every other day. She indicated on 11/30/2016 the order was for Santyl and not collagen. She indicated she was not aware of physician order on 11/21/16 to discontinue Santyl.			

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	The "72 HR ADMISSION/RE-ADMISSION CHARTING" dated 10/18/16 at 5:33 A.M. indicated SKIN CONCERNS: skin concerns observed: WN follows res Sacrum 3 x 1.2 x 0.1 CM. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/7/2016 at 10:47 A.M. indicated wound to coccyx was unstageable and measured 2.5 x 1.8 CM, wound base 100% slough, dressing was Santyl and foam cover daily. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/14/2016 at 5:20 P.M. indicated wound to coccyx was unstageable measured 2.5 x 1.3 CM, wound base 60% yellow slough and 40% granulation, dressing Santyl and foam cover daily. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/21/2016 at 4:36 P.M. indicated wound to coccyx was a Stage 3 and measured 1.4 x 1.2 x 0.5 CM, wound base 100% granulation, dressing collagen, foam cover, change every other day. The "WOUND CARE SPECIALIST EVALUATION" physician notes dated 11/14/2016 indicated wound to sacrum was unstageable and measured 2.5 x 1.3, wound base not measurable, and			

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	dressing Santyl once daily with dry protective dressing. Wound to left buttock was Stage 2 and measured 1.0 X 1.0 CM, and dressing was foam daily. The "WOUND CARE SPECIALIST EVALUATION" physician notes dated 11/21/2016 indicated wound to sacrum was Stage 3 and measured 1.4 X 1.2 X 0.5 CM, wound base 100% granulation and dressing collagen dressing three times per week covered with foam, discontinue Santyl once daily. Record review of "Treatment Administration Record" for the month of November indicated that Santyl was applied to dressing once daily at 7:30 A.M. from 11/21/2016 through 11/30/2016. Order to wound cleanse, pat dry, apply collagen with bordered foam to cover in the morning every other day at 6:00 A.M. was completed 11/23/16, 11/25/2016, 11/27/2016, and 11/29/2016. The care plan indicated resident had a pressure area to the coccyx admitted with related to immobility last revision date 9/08/2016 with interventions that included, but were not limited to pressure reducing mattress on bed, and administer treatments as ordered and monitor effectiveness. The "Measurement & Assessment of			

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	Pressure Ulcers, Wounds, and Other Skin Problems" was provided by the Director of Nursing on 12/1/2016 at 10:00 A.M. This current guideline indicated the following: "Policy: At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and describe skin conditions... All ulcers (Pressure, arterial, diabetic, and venous) will be measured weekly and results recorded on a Wound Assessment Form...." The "Dressing- Non Sterile (Aseptic)" was provided by the Director of Nursing on 12/1/2016 at 3:00 P.M. This current guideline indicated the following: "PURPOSE: To Protect open wounds from contamination... PROCEDURE: 1. Prior to beginning treatment: a. Check physician order and resident allergies...." 4. During interview on 11/30/2016 at 2:41 P.M., CNA (Certified Nursing Assistant) #52 indicated that Resident #66's most recent fall occurred about 1 month ago in dining room. She indicated that CNAs updated in verbal reports regarding new interventions and recent falls. During an interview on 11/30/2016 at 3:04 P.M., the DON indicated			

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	interventions to prevent falls were located in the Kardex and tasks section in PointClickCare or through communication with LPNs (Licensed Practical Nurse) or RNs (Registered Nurse). During observation on 11/30/2016 at 1:33 P.M., Resident #66 was observed sitting on couch watching TV with one sock on right foot, and no sock on left foot. During an observation on 11/30/2016 at 2:28 P.M., Resident #66 was observed sitting on couch watching TV on unit with no sock on left foot, and regular white sock on right foot. There were no non-skid socks present. Resident #66 clinical review was conducted on 12/2/2016 and indicated resident had had 4 falls since 8/25/2016. Falls had occurred in 8/25/2016, 9/22/2016, 11/2/2016, and 11/20/2016. Fall IDT (Interdisciplinary Team) Note dated 8/25/2016 at 10:09 A.M., indicated intervention was resident to have non skid socks of shoes on while up. Fall Occurrence report dated 9/22/2016 at 3:15 P.M. indicated resident was found sitting on floor in hallway and a predisposing situation factor indicated improper footwear, other information			

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	description indicated no shoes or socks on bilateral feet. FALL-INITIAL OCCURRENCE REPORT dated 11/2/2016 at 7:00 A.M. indicated resident had witness fall in hallway, new intervention was lights to be turned on. FALL-INITIAL OCCURRENCE NOTE on 11/20/16 at 6:15 PM indicated resident had an unwitnessed fall in dining room, new intervention was better non-skid foot wear. Review of care plan indicated resident was a risk for falls related to wandering, gait disturbance, and diagnosis of dementia. Interventions undated on 8/25/2016 reflected resident to have shoe or non-skid socks on while out of bed. 5. During observation on 11/29/2016 at 2:02 P.M., Resident #48 had been in same position in dining room since first observed at 9:30 A.M. There was a strong ammonia smell coming from resident. During an observation on 12/01/2016 at 1:07 P.M., Resident #48 was observed sitting at lunch table, still had eggs left on pants from breakfast. Resident's hair appeared greasy. During an interview on 12/01/2016 at 1:10 P.M., LPN #51 indicated Resident #48 was on a check and change program			

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	every 2 hrs. She indicated the resident does not use the toilet because she is a hoyer lift. During an interview on 12/02/2016 at 2:15 P.M., CNA #54 and CNA #55 indicated Resident #48 shower day were on Monday and Thursday. She indicated Resident #48 is unable to refuse showers due to she was non verbal. She indicated staff would not know if she did not want shower. She indicated there was not any reason Resident #48 wouldn't have got her shower on scheduled days. Resident #48 clinical record was reviewed on 12/2/2016 at 2:30 P.M. The resident's diagnoses included, but were not limited to Alzheimer's Disease, anxiety disorder, and muscle weakness. The resident's annual Minimum Data Set (MDS) assessment, dated 9/10/2016, indicated resident required extensive assistance with 2 person assist for toileting and she was frequently incontinent. The look back report for bathing indicated Resident #48 had received shower on 11/3/2016, 11/7/2016, 11/10/2016, and 11/28/2016. The care plan indicated resident was incontinent of bowel and bladder related			

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	to cognitive status and behaviors with interventions that included, but were not limited to check and change every 2 hours and as needed. The "Care Plan Guidelines" was provided by the Director of Nursing on 11/30/2016 at 3:00 P.M. This current guideline indicated the following: "Objective: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining optimal status. 5. ...services provided and arranged must be consistent with each resident's written plan of care...." During an interview on 12/2/2016 at 3:30 P.M., DON indicated that 4 showers in one month was not acceptable. 3.1-35(g)(2)			
F 0309 SS=G Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that			

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	applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on interview and record review, the facility failed to provide timely pain management for 2 of 3 residents reviewed for pain resulting in Resident B and Resident C experiencing 10/10(a pain scale - 0 being no pain at all, 10 being the worst pain you have experienced) pain, with no relief. Findings include: 1. A clinical record review was completed on 12/1/2016 at 9:30 A.M., and indicated Resident B was admitted	F 0309	**F 309** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	01/04/2017

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	on 3/28/2016. His diagnoses included but were not limited to: muscle weakness, history of falling, osteoporosis, seizures, dysphagia, anxiety, dementia, bipolar, schizoaffective disorder, and multiple sclerosis. A physician order dated 11/28/2016 indicated Resident B was to have norco 5/325mg (a pain medication) every 4-6 hours as needed. A "CONTROLLED DRUG RECIEPT/RECORD/DISPOSITION FORM" indicated Resident B did not receive norco 5/325mg until 11/29/2016 at 4:23 P.M.. A nurses note dated 11/28/2016 at 2:00 P.M., indicated Resident B returned from a dental appointment with dentures in place and received a prescription for norco 5/325mg. During an interview on 11/29/2016 at 8:40 A.M., Resident B indicated he had his upper teeth removed yesterday and dentures put in place. He indicated he was supposed to go back to the dentist because the facility had not filled his prescription as of yet and they are waiting on the pharmacy to fill his prescription this morning. He further indicated he was in pain.		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #B, Pain level was assessed on 12/5/16. The physician was notified with no new orders. Pain medications ordered are present in medication cart. Resident #C, This resident no longer resides in the facility. **2) How the facility identified other residents:** A Cart to Chart Audit was conducted on 12/18/16 by the pharmacy to identify potential unavailable medications with no pain medications unavailable	

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	During an interview on 11/30/2016 at 2:45 P.M., Resident B indicated he feels a lot better since he received his pain medication. Resident B was observed sitting in his wheelchair with gauze in his mouth. His dentures and the gauze had areas of saliva and blood to them. He was observed to have bruising to his cheeks. During an interview on 11/30/2016 at 3:00 P.M., the DON (Director of Nursing) indicated Resident B was offered tylenol and norco when he returned on 11/28/2016 and was educated that the facility would have to get a release from the pharmacy to pull a norco from their EDK (emergency drug kit). She than indicated Resident B agreed to take Tylenol for his pain. The DON indicated Resident B should not have gone 24 hours without his prescription pain medication. During an interview on 12/1/2016 at 1:48 P.M., Resident B indicated he was in pain the evening of his oral surgery. He scored his pain a 10 out of 10 on a pain rating scale (0 being no pain at all and 10 being the worst pain you have ever experienced). He further indicated the facility did not give him any pain medication that helped with his pain that		noted in the findings. An audit was completed on all residents receiving pain medication. The Emergency Drug Kit was audited by the pharmacy to determine availability of pain medications when awaiting scripts from new admits. **3) Measures put into place/ System changes:** Educate Licensed Nurses on the process of obtaining pain medication timely when the pharmacy cannot deliver and or obtaining and acceptable alternative. Using the EDK for back up. Timely administration and documentation. A medication cart audit of new admissions will take place on next shift to ensure medications available and appropriate.	

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	evening. He indicated the facility gave him Tylenol and this did not help his pain. He indicated the staff told him his prescription medication was not available in the facility and that it would take longer to obtain pain medication other than Tylenol. 2. A clinical record review was completed on 12/1/2016 at 2:45 P.M., and indicated Resident C was admitted on 10/28/2016. His diagnoses included but were not limited to: stable burst fracture of first lumbar vertebra, sleep disorder, hypertension, tramatic subdural hemorrhage without loss of consciousness, ileus, depressive episodes, hemiplegia and hemiparesis following nontaumatic intracerebral hemorrhage affecting right dominant side, intervertebral disc degeneration lumber region, and difficulty in walking. During an interview on 12/1/2016 at 9:15 A.M., a family member indicated Resident C had contacted him to tell him that he was in pain and the facility did not have his pain medication. A nurses note indicated Resident C arrived at the facility following back surgery on 10/28/2016 at 5:50 P.M. and physician orders were verified.		**4) How the corrective actions will be monitored:** The Director of Nursing or Designee will review new pain medication order receipts and EDK use 3 times a week and place finding on an audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 1-4-17	

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	A physician order dated 10/28/2016 indicated Resident C was to have oxycodone-acetaminophen 5/325(a pain medication) mg (milligram) every four hours as needed for pain. A nurses note dated 10/28/2016 at 9:28 P.M., indicated facility staff contacted a physician for a one time order to give two hydrocodone-acetaminophen 10/325 mg (a pain medication) and again at 6:00 A.M. and until his prescription medication arrives from the pharmacy. MAR (Medication Administration Record) reviewed and indicted Resident C did not recieve a pain medication on 10/28/2016 until 11:59 P.M. During an interview on 12/1/2016 at 1:15 P.M., DON indicated it should never take 3 to 6 hours for the facility to dispense a pain medication to a resident. She indicated that at the very longest, it should take one hour. During an interview on 12/1/2016 at 1:40 P.M., LPN #31 and LPN #32 indicated Resident C did not receive a pain medication the day he was admitted to the facility. They indicated Resident C should have received a pain medication when he returned from the hospital, however the medication was not			

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	available at the facility for the nurses to dispense to Resident C. They further indicated that pharmacy does sometimes take longer than they should to fill a prescription for residents. A policy was provided by the DON on 12/1/2016 at 12:22 P.M., titled "PAIN MANAGEMENT PROGRAM" dated 1/1/2014, and indicated this was the policy currently used by the facility. The policy indicated "...It is the policy of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program...." This Federal tag relates to complaint IN00213797. 3.1-37 (a)			
F 0314 SS=G Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed follow physician orders and measure a pressure ulcer timely, resulting in the Stage III pressure area measuring 1.4cm x 1.2cm x 0.5cm (centimeters) to an Unstageable measuring 2.0cm x 1.4cm x 0.7cm. (Resident #71) Finding includes: 1. During an observation on 11/30/2016 at 5:24 P.M., the Wound Nurse (WN) removed the foam dressing dated 11/30 from the sacral region of Resident #71. Pale yellow slough was observed in the base of wound the size of a nickel. The WN indicated wound measurement was 2.0cm (centimeters) x 1.4cm x 0.7cm. She described the base of wound as 90% slough and 10% epithelial tissue and the current stage III wound was now unstageable wound.	F 0314	**F 314** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	01/04/2017

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	During an interview on 11/30/2016 at 5:30 P.M., the Wound Nurse indicated the current dressing was collagen covered with foam to be changed every other day, and she indicated collagen was not present in the wound dressing during observation of dressing removal and measurement. Wound nurse indicated wound measurement completed on 11/28 are not available. She indicated measurements from 10/18/16 to 11/7/16 were not completed. She indicated she used the measurements from the wound doctor and did not measure the wounds herself. During an interview on 12/01/2016 at 2:16 P.M., WN indicated that wound measurements from left and right buttocks observed on 10/18/16 were not completed, she indicated wound physician incorporated all wound measurements together. She indicated she used the measurements from the physician for facility wound log and skin reports. During an interview on 12/01/2016 at 2:50 P.M., the DON (Director of Nursing) indicated the wound nurse has not had any wound education other than a one day wound seminar attended in late October. She indicated there was not a		**1) Immediate actions taken for those residents identified:** Resident #71, the physician was notified of the status of her wound. Treatment orders clarified and initiated. **2) How the facility identified other residents:** An audit of resident's who are followed in wound rounds was completed to verify accurate documentation of wound status and appropriate treatment orders. **3) Measures put into place/ System changes:** Education was provided to the nurse assigned to measure, track and document wound progress i.e., when to measure, how to measure, how to document and complete wound tracking log. Expectations of what is required of the wound nurse.	

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	job description for wound nurse in employee's file. She indicated that wound measurements should be completed every seven days and physician orders are to be followed in regards to treatments. During an interview on 12/2/2016 at 10:00 A.M., the DON indicated Resident #71 had two different orders. Santyl was ordered daily at 6:00 A.M. and collagen covered with foam was ordered every other day. She indicated on 11/30/2016 the order was for Santyl and not collagen. She indicated she was not aware of physician order on 11/21/16 to discontinue Santyl. The "72 HR ADMISSION/RE-ADMISSION CHARTING" dated 10/18/16 at 5:33 A.M. indicated SKIN CONCERNS: skin concerns observed: WN follows res Sacrum 3 x 1.2 x 0.1 CM. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/7/2016 at 10:47 A.M. indicated wound to coccyx was unstageable and measured 2.5 x 1.8 CM, wound base 100% slough, dressing was Santyl and foam cover daily. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/14/2016 at 5:20 P.M. indicated wound to coccyx was unstageable measured 2.5		Supervision of the Wound Nurse will be monitored by the MDS Coordinator. **4) How the corrective actions will be monitored:** The MDS Coordinator will review wound documentation and care plan 3 times per week and place findings on an audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 1-4-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	12/05/2016

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	x 1.3 CM, wound base 60% yellow slough and 40% granulation, dressing Santyl and foam cover daily. "SKIN-PRESSURE/DIABETIC/VENOUS/ARTERIAL WOUND REPORT" dated 11/21/2016 at 4:36 P.M. indicated wound to coccyx was a Stage 3 and measured 1.4 x 1.2 x 0.5 CM, wound base 100% granulation, dressing collagen, foam cover, change every other day. The "WOUND CARE SPECIALIST EVALUATION" physician notes dated 11/14/2016 indicated wound to sacrum was unstageable and measured 2.5 x 1.3, wound base not measurable, and dressing Santyl once daily with dry protective dressing. Wound to left buttock was Stage 2 and measured 1.0 X 1.0 CM, and dressing was foam daily. The "WOUND CARE SPECIALIST EVALUATION" physician notes dated 11/21/2016 indicated wound to sacrum was Stage 3 and measured 1.4 X 1.2 X 0.5 CM, wound base 100% granulation and dressing collagen dressing three times per week covered with foam, discontinue Santyl once daily. Record review of "Treatment Administration Record" for the month of November indicated that Santyl was applied to dressing once daily at 7:30 A.M. from 11/21/2016 through			

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	11/30/2016. Order to wound cleanse, pat dry, apply collagen with bordered foam to cover in the morning every other day at 6:00 A.M. was completed 11/23/16, 11/25/2016, 11/27/2016, and 11/29/2016. The care plan indicated resident had a pressure area to the coccyx admitted with related to immobility last revision date 9/08/2016 with interventions that included, but were not limited to pressure reducing mattress on bed, and administer treatments as ordered and monitor effectiveness. The "Measurement & Assessment of Pressure Ulcers, Wounds, and Other Skin Problems" was provided by the Director of Nursing on 12/1/2016 at 10:00 A.M. This current guideline indicated the following: "Policy: At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and describe skin conditions... All ulcers (Pressure, arterial, diabetic, and venous) will be measured weekly and results recorded on a Wound Assessment Form...." The "Dressing- Non Sterile (Aseptic)" was provided by the Director of Nursing on 12/1/2016 at 3:00 P.M. This current guideline indicated the following: "PURPOSE: To Protect open wounds			

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	from contamination... PROCEDURE: 1. Prior to beginning treatment: a. Check physician order and resident allergies...." 3.1-40(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on interview, observation, and	F 0323	**F 323**	01/04/2017

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	record review the facility failed to ensure the resident environment remained as free from accident hazards as possible as evidenced by multiple falls that occurred due to interventions not being followed in 1 or 4 residents. (Resident #66) Finding includes: 1. During interview on 11/30/2016 at 2:41 P.M., Certified nursing assistant (CNA) #52 indicated that Resident #66's most recent fall occurred about 1 month ago in dining room. She indicated that CNAs updated in verbal reports regarding new interventions and recent falls. During an interview on 11/30/2016 at 3:04 P.M. , the DON (Director of Nursing) indicated interventions to prevent falls were located in the Kardex and tasks section in PointClickCare or through communication with LPNs (Licensed Practical Nurse) or RNs (Registered Nurse). During observation on 11/30/2016 at 1:33 P.M., Resident #66 was observed sitting on couch watching TV with one sock on right foot, and no sock on left foot. During an observation on 11/30/2016 at 2:28 P.M., Resident #66 was observed		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #66, falls have been reviewed and fall risk care plan/ kardex have been updated. **2) How the facility identified other residents potentially affected:** All residents at risk for falls have the potential to be affected. Residents at risk for falls have been identified and interventions and plan of care have been reviewed.	

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	sitting on couch watching TV on unit with no sock on left foot, and regular white sock on right foot. There were no non-skid socks present. Resident #66 clinical review was conducted on 12/2/2016 and indicated resident had had 4 falls since 8/25/2016. Falls had occurred in 8/25/2016, 9/22/2016, 11/2/2016, and 11/20/2016. Fall IDT (Interdisciplinary Team) Note dated 8/25/2016 at 10:09 A.M., indicated intervention was resident to have non skid socks of shoes on while up. Fall Occurrence report dated 9/22/2016 at 3:15 P.M. indicated resident was found sitting on floor in hallway and a predisposing situation factor indicated improper footwear, other information description indicated no shoes or socks on bilateral feet. FALL-INITIAL OCCURRENCE REPORT dated 11/2/2016 at 7:00 A.M. indicated resident had witness fall in hallway, new intervention was lights to be turned on. FALL-INITIAL OCCURRENCE NOTE on 11/20/16 at 6:15 P.M. indicated resident had an unwitnessed fall in dining room, new intervention was better non-skid foot wear. Review of care plan indicated resident was a risk for falls related to wandering, gait disturbance, and diagnosis of dementia. Interventions undated on		**3) Measures put into place/systems changes:** Licensed nurses will be re-educated on following the plan of care to ensure safety interventions are in place. Non-licensed personnel will be re-educated on following the resident Kardex to ensure safety interventions are in place. **4) How the corrective actions will be monitored:** Observation rounds will be completed on at least 5 residents identified as high risk for falls per week on varied shifts to ensure safety interventions and devices are in place and plan of care is being followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **1-4-17**	

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	8/25/2016 reflected resident to have shoe or non-skid socks on while out of bed. The "Care Plan Guidelines" was provided by the Director of Nursing on 11/30/2016 at 3:00 P.M. This current guideline indicated the following: "Objective: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining optimal status. 5. ...services provided and arranged must be consistent with each resident's written plan of care...." 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse			

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	consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure there was proper indication for use of a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #85). Finding includes: Record review for Resident #85 began on 11/30/16 at 10:41 A.M.. Diagnoses for the resident included but, were not limited to, Alzheimer's disease, lung cancer, sleep disorder, anxiety disorder and adjustment disorder with depressed mood. Physician's orders included, but was not limited to, "...Divalproex Sodium Tablet Delayed Release [a mood stabilizer or anticonvulsant] 125 MG [milligrams] by mouth one time a day for Anticonvulsant...." During an interview on 12/2/16 at 9:20 A.M., the SSD (Social Service Director) indicated the resident did not have a seizure disorder and indicated the Divalproex was being used as a mood stabilizer. She indicated he was admitted to the facility on the medication.	F 0329	**F 329** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #85- No longer resides in this facility. **2) How the facility identified other residents potentially affected:** A review of medication orders	01/04/2017

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	On 12/2/16 at 9:44 A.M., the SSD provided the policy titled "Psycopharmacological Medications," dated 9/1/16, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy It is the policy of this facility to assure each resident's drug regimen is free from unnecessary drugs... Standard Each resident's drug/medication regimen shall be managed and monitored by the interdisciplinary team and reviewed with the physician and pharmacist to: 1. achieve the resident's highest praticable physical, mental and psychosocial well-being, 2. to assure the resident is receiving only those medications, in doses and for the durations clinically indicated to treat the individual's assessed conditions... Provisions Medication management is based in the care process and includes...3. Diagnoses/cause identification...." 3.1-48(a)(4)		and diagnosis for all resident's receiving psychoactive and anticonvulsant medications was completed to ensure that an appropriate diagnosis is identified. **3) Measures put into place/systems changes:** The Social Service Director and Nursing Management will review new medication orders during clinical meetings to ensure appropriate diagnosis is in place. New admissions will be reviewed the next business day to ensure appropriate diagnosis is in place. Medications & Diagnosis will be reviewed by psych services quarterly to determine efficacy of use. GDR's will be determined quarterly. **4) How the corrective actions will be monitored:** The Social Service Director will complete and audit weekly on residents with new orders for psychotropic and anticonvulsant medications. The results of these audits will be reviewed in Quality Assurance	

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			Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. **Date of compliance:** 1-4-17	
F 0334 SS=D Bldg. 00	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's			

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	representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education			

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	regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review the facility failed to offer a pneumococcal vaccination to 2 of 5 residents reviewed for immunizations. (Resident's #14 and #33) Findings include: An immunization record review was completed for Resident #14 and indicated Resident #14 was not offered a pneumococal vaccination. An immunization record revew was completed for Resident #33 and indicated Resident #33 was not offered a pneumococcal vaccination. During an interview on 12/2/2016 at 2:29 P.M., DON (Director of Nursing) indicated Resident #14 and Resident #33 were not offered a pneumococcal vaccination. A policy was provided by the DON on 12/1/2016 at 12:22 P.M., titled "Policy for Pneumococcal Vaccination of Residents" undated, and indicated this	F 0334	**F 334** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	01/04/2017

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	was the policy currently used by the facility. The policy indicated "...It is the policy of this facility that each resident or their responsible party will be asked on admission if they have previously had the pneumococcal vaccination and their age at the time of vaccination. The records that accompany the residnt also will be used to determine immunization status. If ther is no prior evidence of caccination, the vaccine will be offered to the resident at that time...." 3.1-13(a)		Resident #14, Pneumococcal Consent form was mailed to the resident's responsible party on 12/6/16. The Responsible party was called on 12/6/16 and message left to call facility regarding consent form. Verbal consent given to give on 12/23/16. Resident #33, consent refused for Pneumococcal Vaccine on 12/2/16 **2) How the facility identified other residents:** A complete audit of current residents, was conducted on 12/6/16 to identify other residents who had the potential to be affected. **3) Measures put into place/ System changes:** Education was provided to the admissions/marketing director on when admission paperwork is completed, a consent for	

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			pneumococcal and influenza must be obtained. If refused, a reason needs to be included. Education was provided to the licensed nurses to obtain orders for administration and document date of administration in the resident's medical record if a consent is signed. New admissions will be audited in morning clinical meeting within 1 business day to verify immunization consents are signed, orders written, & immunization administered if applicable. **4) How the corrective actions will be monitored:** Medical Records will review all admission consents daily and place findings on and audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and	

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			make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 1-4-17	
F 0364 SS=D Bldg. 00	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; Based on observation, interview and record review, the facility failed to serve food at proper temperatures to 2 of 18 residents' trays on South Hall, and from steam tray on West Hall. Findings included: During an observation on 11/28/2016 at 12:54 P.M., dietary aide, #56 indicated the temperature of the piece of chicken served to resident was 96 degrees and the stuffed green pepper served to resident	F 0364	**F364** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	01/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was 90 degrees. The dietary aide indicated she would replace residents' food with new items. During an observation on 11/30/16 at 12:05 P.M., Dietary cook indicated the temperature of the peas was 130 degrees and the mechanical soft meat was at 132 degrees. DM (Dietary Manager) indicated she would bring more but did not have anymore, indicated she would reheat. Mechanical soft meat 132, DA (Dietary Assistant) indicated she had two residents that required mechanical soft meat. DA indicated that hot items needed to be served at temp greater than 145 degrees. During an interview on 11/30/2016 at 12:05 P.M., the dietary cook indicated hot items needed to be served at temperatures above 145 degrees. She indicated that 2 more residents still needed to be served mechanical soft meat. 3.1-21(a)(2)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in the 2567. **2) How the facility identified other residents:** Residents' foods that were still to be passed on 11/30/16 were re-heated per the 2567. **3) Measures put into place/ System changes:** The dietary department were re-in-serviced on proper	

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			temperature to be served to the residents. Residents on room tray carts will be served with appropriate food temperatures. **4) How the corrective actions will be monitored:** The Dietary Service Manage or designee will audit 5 meals per week to include all 3 meals to audit the food temperatures. The Dietary Service Manager will have a test tray for room tray 5 times per week to include all 3 meals for maintaining of temperatures. The Dietary Service Manager will report finding to QA monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1/4/2017**	

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F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to distribute and serve food under sanitary conditions related to the machine washing and sanitizing temperatures not reaching a minimum of 120 degrees for a low temperature dishwasher that had the potential of affecting 64 of 64 residents.	F 0371	**F371** **The facility requests paper compliance for this citation.** *This Plan of Correction is*	01/04/2017

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	Finding includes: During an observation on 11/28/2016 at 11:20 A.M., of the wash and rinse cycle of the low temperature dishwasher, the wash cycle reached 102 degrees and the rinse cycle reached 104 degrees and the Dietary Manager (DM) indicated the wash cycle was 102 degrees and the rinse cycle was 104. The thermostat on the the dishwasher had a sticker that indicated a "minimum of 120 degrees". During an interview on 11/28/2016 at 11:20 A.M., the DM indicated the temperatures usually ran between 90-100 degrees. DM indicated there was not a log book for the dishwasher temperatures available for review. During an interview on 11/28/16 at 11:23 A.M., the DM indicated no dishes were washed using the 3-sink method, all dishes including pans went through the low temperature dishwasher. During an interview on 11/28/2016 at 2:37 P.M., the ADM (Administrator) indicated a local dishwasher repair company would be out on 11/29/2016 to check dishmachine. He indicated a boost machine would be placed or the dishwasher would replaced.		*the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents were served off disposable dishware until the dish washer was repaired. **2) How the facility identified other residents:** All residents had the potential to be affected and all residents were served off disposables until the dish machine was repaired.	

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	During an interview on 12/02/2016 at 1:45 P.M., the DM indicated that all residents receive food from kitchen. One resident received g-tube feeding also received therapeutic meals that are served during therapy. During review of the dishmachine manual provided by the Maintenance Director on 11/29/2016 at 10:00 A.M., the manual indicated the temperature for the wash and rinse cycle was a minimum of 120 degrees. The "protocol for dish machine malfunction" was provided by ADM on 12/1/2016 at 3:00 P.M. The current protocol indicating the following: "Dietary staff is responsible for checking the dish machine temperature each time it is ran and log machine temperature, the time it was ran, then sign and date. If Dish machine is unable to reach temperature of 120 degrees or is not functional, the dietary staff must submit a maintenance order and discontinue dishmachine use until it is functional or meets temps of 120 degrees or higher...." 3.1-21(i)(3)		**3) Measures put into place/ System changes:** The Dietary Manager was re-in-serviced on taking dish temperatures to ensure they are at 120 degrees. **4) How the corrective actions will be monitored:** The Dietary Service Manager will monitor 5 times per week to include all shifts to ensure the dish machine is at the 120 degrees. The Dietary Service Manager will report findings to QA. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			5) Date of compliance: **1-4-2017**	
F 0431 SS=F Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently			

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medication carts were free of loose pills and clean for 4 of 4 medication carts (West Unit, South Unit, Touchstone Terrace Unit and North Unit carts). Finding includes: During a medication storage observation on 12/2/16 at 10:55 A.M., in the second drawer of the West Unit medication cart, there were two dark green round pills, a yellow capsule, two round white pills, two fragments of white pills, and two	F 0431	**F 431** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or*	01/04/2017

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	fragments of yellow pills loose. In the third drawer, there was a dark green pill, a white oval pill, two oblong white pills and a round white pill loose. During an interview on 12/2/16 at 11:03 A.M., LPN (Licensed Practical Nurse) #10 indicated there should not be loose pills in the medication cart and they should be destroyed. She indicated she was unsure of the cleaning schedule but, she thought night shift was responsible for cleaning them. During an interview on 12/2/16 at 11:07 A.M., LPN #11 she indicated the medication carts were supposed to be cleaned weekly on night shift. During a medication storage observation on 12/2/16 at 12:48 P.M., in the second drawer of the South Unit medication cart, there was a white powdered substance along the back edge, two white oval pills, a white round pill, a light blue round pill and one white fragment of a pill. In the third drawer there was a yellow powdered substance along the back right corner and a deteriorated pill. In the fourth drawer there was a yellow powdered substance in the back right corner and a purple powdered substance with fragments of purple pills along the back edge.		*agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** West Unit Medication Cart was cleaned on 12/8/16 South Unit Medication Cart was cleaned on 12/8/16 Touchstone Terrace Unit Medication Cart was cleaned on 12/8/16 North Unit Medication Cart was cleaned on 12/8/16 **2) How the facility identified other residents:** All Medication and Treatment Carts were cleaned on 12/8/16	

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	During an interview on 12/2/16 at 12:48 P.M., RN (Registered Nurse) #12 indicated she did not know what the powdered substances were in the drawers, how often medication carts were cleaned or who was responsible for doing it. She indicated the loose pills should have been destroyed. During a medication storage observation on 12/2/16 at 12:59 P.M., in the first drawer of the Touchstone Terrace Unit medication cart there were two pennies and a brown powdered substance in back right corner and a knife. In the second drawer there was a white powdered substance in the right back corner, one peach-colored pill, one white oval pill, one peach colored fragment of a pill and one fragment of a white pill loose. In the third drawer there was a multi-colored powdered substance and a loose white capsule. In the fourth drawer there was a white powdered substance along the back edge. During an interview on 12/2/16 at 12:59 P.M., RN #12 indicated she did not know why there were pennies or a knife in the medication cart and she did not know what the powdered substances were in the drawers. During a medication storage observation		**3) Measures put into place/ System changes:** A cleaning schedule with assignment of shift responsible was developed and placed on each unit. A check off sheet will be placed on each unit to indicate carts have been cleaned **4) How the corrective actions will be monitored:** The Medical Records Supervisor will review check off sheets weekly and place finding on an audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 1-4-17	

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	on 12/2/16 at 1:11 P.M., in the first drawer of the North Unit medication cart there were white fragments of pills in left back corner. In the second drawer there was one white pill fragment. In the third drawer there was a white powdered substance along the back edge. During an interview on 12/2/16 at 1:11 P.M., LPN #13 indicated third shift nurses were responsible for cleaning the medication carts weekly. She indicated the loose pill fragments should have been destroyed. On 12/2/16 at 12:50 P.M., the Director of Nursing provided the policy titled "MEDICATION STORAGE, LABELING AND EXPIRATION DATES," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...APPLICABILITY: This Policy sets forth the guidelines relating to the storage and expiration dates of medications, biologicals, syringes and needles... 3. General Storage Procedures... 4. Facility should ensure that medications and biologicals that... (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier... 16. Facility should destroy or return all discontinued, outdated/expired, or			

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	deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines or other Applicable Law. 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis...." 3.1-25(j) 3.1-25(o)			
F 9999 Bldg. 00	3.1-14 PERSONEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule is not met as evidenced by: Based on interview and record review the faciliy failed to ensure LPN #35 had an active license. This deficient practice had the ability to affect 1 of 10 employee records reviewed. Findings include: A review completedon 12/2/2016 at 9:35 A.M., indicated LPN (Licensed Practical Nurse) #35 had an expired license as of 10/31/2016.	F 9999	**F9999** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it*	01/04/2017

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	A schedule print off from the facility time clock indicated LPN #35 had worked on October 30, 31, November 1, 2, 3, 5, 6, 2016 on the evening shift. During an interview on 12/2/2016 at 1:25 P.M, the DON (Director of Nursing) indicated LPN #35's license was expired and that she had worked several shifts while it was expired. A "Job Description & Performance Montiroing System" for a "Staff Nurse - LPN" indicated a facility staff LPN (Licensed Practical Nurse) should have at a minimum "...A graduate of an accredited school of nursing and possess a valid LPN license in good standing according to State and Federal requirements...."		*is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** LPN #35, on 12/2/16 the license was activated. **2) How the facility identified other residents:** An audit of licensed staff was conducted with no further negative findings. **3) Measures put into place/ System changes:** Annually on the first business day of November, the HR will run the licenses of the LPNs on the even years and RNs on the odd years for current employees. New perspective employees will have their licensed verified before hire.	

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			4) How the corrective actions will be monitored: The DON or designee will review licenses annually and upon hire and place findings on an audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 1-4-17**	