STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	07/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVE LA PORTE, IN 46350

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00202871. Complaint IN00202871- Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312, and F364. Survey dates: July 21, 22, 23, 25, 26, and, 27, 2016 Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census bed type: SNF/NF: 121 Total: 121 Census payor type: Medicare: 9 Medicaid: 95 Other: 17 Total: 121 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This Plan of Correction shallserve as this facility's credibleallegation of compliance.Preparation, submission, andimplementation of the Plan ofCorrection does not constitute anadmission of or agreement withthe facts and conclusions setforth in this survey report. OurPlan of Correction is preparedand executed as a means tocontinuously improve the qualityof care and to comply with allapplicable state and federalregulatory requirements. Pleaseconsider allowing the submissionof living center audits andeducation as evidence ofcompliance with the state andfederal requirements identified inthe survey. Respectfully, JerrellHarville, HFA, MSW, ExecutiveDirector.	

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

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	Quality review completed by 32883 on 7/28/16.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of			

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	the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure each resident's Responsible Party was notified of new medication orders for 1 of 1 residents reviewed for notification of change. The facility also failed to ensure a resident's Responsible Party was notified prior to transferring funds from the resident's personal funds account for 1 of 3 people reviewed for personal funds. (Residents #68 and #119) Findings include: 1. The record for Resident #68 was reviewed on 7/27/16 at 11:29 a.m. The resident's diagnoses included, but were not limited to, schizophrenia and multiple sclerosis. A Physician's order dated 7/6/16, indicated the resident was to receive Zofran (a medication to prevent nausea and vomiting) 4 milligrams (mg) three times a day (tid) before meals (ac). An entry in the Nursing Progress notes dated 7/6/16 at 3:50 p.m., indicated the resident had a new order for Zofran 4 mg tid ac. The guardian was called and a message was left to return the call about the new order. There was no further	F 0157	Step One: 1.The resident's Physician Order Summary was reviewed with the Guardian for Resident #68 and she verbalized understanding. 2.The identified resident/responsible party was notified of any financial transactions Step Two: 1.The medical records were reviewed for all current residents for the past 60 days to ensure appropriate physician and/or family notification. Any deficiencies noted were corrected. 2.Residents/responsible parties who utilize the Resident Trust Service have the potential to be affected. All transactions will be signed off on by resident or responsible parties prior to their occurrence. Step Three: 1.Licensed Nursing Staff were re-instructed regarding the policy for Notification of Change in Resident Health Status. The DNS and/or designee will audit five random medical records per unit weekly. The audit findings will be reported to the QAPI Committee monthly. 2.Executive Director or designee will review transactions at least 1 x weekly to ensure proper signage and/or documentation is present for	08/26/2016

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	documentation to indicate if the resident's guardian had been notified about the Zofran. A Nurse Practitioner order dated 7/11/16, indicated the resident was to receive Meloxicam (an anti-inflammatory medication) 7.5 mg daily. An entry in the Nursing Progress notes dated 7/11/16 at 4:03 p.m., indicated the Family Nurse Practitioner was in and a new order for 7.5 mg of Meloxicam once daily was ordered. A message was left with the resident's Mother to call the facility back. There was no further documentation to indicate if the resident's guardian (Mother) was notified. Interview with the Rainbow Unit Manager on 7/27/16 at 2:45 p.m., indicated follow up documentation should have been completed related to Guardian notification of the new medications. The Notification of Change in Resident Health Status policy was reviewed on 7/27/16 at 3:15 p.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the following: "The center will consult the resident's physician, nurse practitioner or physician		Resident Trust transactions. This will be ongoing. Step Four: 1.The results of the Notification Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficientpractices will be considered a trend or pattern), the results will be reviewed quarterly. 2.The results of the Transaction Audit will be reviewed in the Managers Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	assistant, and if known notify the resident's legal representative or an interested family member when there is: A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)." 2. The personal funds account for Resident #119 was reviewed on 7/26/16 at 10:44 a.m. The resident's account indicated she was within $200 of the eligibility limit for Medicaid. Interview with the Business Office Manager at that time, indicated Receptionist #1 wrote a check for $1000.00 from the resident's account to another facility where the resident's spouse resided. She further indicated they had phoned the facility to see if the spouse needed funds. The POA (Power of Attorney) was notified by phone of the balance, but was not notified the facility would be transferring the funds. She further indicated the Business Office had nothing in writing authorizing the facility to transfer the funds. Interview with the Administrator on 7/26/16 at 10:50 a.m., indicated the facility should have received authorization in writing from the POA prior to the transfer of funds.			

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	3.1-5 (a)(2) 3.1-5 (a)(3)			
F 0159 SS=D Bldg. 00	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.			

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	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to ensure residents had access to their funds in the evenings and on weekends for 3 of 3 residents reviewed for personal funds of the 3 residents who met the criteria for personal funds. (Residents #39, #50, and #84) Finding includes: Interview with Resident #39 on 7/21/16 at 2:46 p.m., indicated she was unable to get money from her personal funds account on the weekends. Interview with Resident #50 on 7/22/16	F 0159	Step 1 - Corrective action for identified residents #39, #50, and #84, includes the Resident Council proposal to have banking hours posted that are from 9:30 a.m. until 4:30p.m. Monday thru Friday and on weekends from 10- a.m. until 2 p.m. Resident Council request will be honored. Step 2 - All residents who maintain a Resident Trust Account within the facility are potentially affected by this deficiency. Resident Council proposal to have banking hours posted that are from 9:30 a.m. until 4:30p.m Monday thru Friday and on weekends from 10- a.m. until 2 p.m. Step 3 - Signage will be posted to show hours of "Banking Operations" so that residents can effectively draw out	08/26/2016

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	at 9:51 a.m., indicated she was unable to get any money from her personal funds account on the weekends. Interview with Resident #84 on 7/22/16 at 11:48 a.m., indicated she was not able to get any money from her personal funds account on the weekends. The Business Office sign located on the reception desk indicated "During the week please see the business office to access your funds. If the office is closed, please see the evening manager to get access to your funds." The sign did not indicate any available weekend hours. Interview with Receptionist #1 on 7/26/16 at 9:14 a.m., indicated all of the above residents had a personal funds account with the facility. She further indicated the resident's funds were kept in a coded lock box inside a locked filing cabinet. She also indicated the facility does not have an evening manager and there was not anyone else after 5:30 p.m. or weekends with the key to the cabinet or code to the box. Interview with the Administrator on 7/26/16 at 10:58 a.m., indicated that he was not aware of the business office sign. He further indicated the facility did not have an evening manager, and there was		funds to meet their individual needs. Banking hours of operation will be consistent with Resident Council request and Staff who manage the front desk/resident bank, will be trained to dispense funds within designated hours Step 4 - - Resident Council will be interviewed monthly x 6 months to ensure deficiency is resolved. Results of interviews will be reviewed monthly in QAPI x 6 months to determine any pattern of deficiency. If no pattern results it will be reviewed quarterly x 6 months. Step 5 - These remedies will be in place by August 26, 2016.	

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	no one in the facility after 5:30 p.m. or weekends that had access to the filing cabinet or lock box to assist the residents with withdrawal of their funds. 3.1-6 (f)(1)			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to covering urinary catheter drainage bags with dignity bags for 3 of 3 residents reviewed with urinary catheters. (Residents #1, #35, and #197) Findings include: 1. On 7/25/16 at 8:39 a.m., 10:40 a.m., and 2:00 p.m., Resident #1 was observed in bed. The resident's Foley (urinary) catheter bag was draining dark amber urine. The Foley catheter drainage bag was not covered and the urine in the bag was visible from the hallway. On 7/26/16 at 9:14 a.m., the resident was observed in bed. The resident's Foley	F 0241	Step One: The Foley Catheter Bags were placed in a dignity bag for Residents #1, #35, and #197. Step Two: All residents with current physician orders for an indwelling catheter were visually inspected to ensure proper placement in a dignity bag. Any deficiencies noted were corrected. Step Three: Nursing Staff were re-instructed regarding proper placement of an indwelling catheter bag in a dignity bag at all times. The DNS and/or designee will visually inspect two random residents with indwelling catheters per unit weekly to ensure proper placement in a dignity bag. The audit findings will be reported to the QAPI Committee monthly. Step Four: Step IV: The results of the Dignity Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be	08/26/2016

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	catheter bag was draining dark amber urine. The Foley catheter drainage bag was not covered and the urine in the bag was visible from the hallway. The record for Resident #1 was reviewed on 7/25/16 at 8:51 a.m. The resident's diagnoses included, but were not limited to, palliative care, pain, heart failure, and femoral fracture. A Physician's Order dated 7/22/16 indicated the resident could have a Foley catheter placed for comfort. Interview with the Rainbow Unit Manager on 7/26/16 at 9:34 a.m., indicated that she would get a dignity bag for the resident's Foley catheter drainage bag and the urine in the bag should not have been visible from the hallway. 2. On 7/21/16 at 9:00 a.m., Resident #197 was observed lying in bed. There was a urinary catheter bag observed hanging from the side of the bed. A large amount of yellow urine was visible from the hallway in the urinary catheter bag. The record for Resident #197 was reviewed on 7/27/16 at 2:51 p.m. The resident's diagnosis included, but were not limited to, dementia with behaviors, urinary retention, altered mental status, and hypertension. The resident had an		reviewed monthly by the QAPI Committee for six months. If after six months of reviewwithout any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	indwelling Foley catheter. Interview with the Director of Nursing on 7/27/16 at 11:38 a.m., indicated the urinary catheter bag should have been placed inside of a dignity bag. 3. On 7/21/16 at 9:02 a.m., Resident #35 was observed lying in bed. There was a urinary catheter bag observed hanging from the side of the bed. A small amount of yellow urine was visible from the hallway in the urinary catheter bag. The record for Resident #35 was reviewed on 7/27/16 at 2:58 p.m. The resident's diagnosis included, but were not limited to, paraplegia and pressure ulcers. The resident had an indwelling Foley catheter. Interview with the Director of Nursing on 7/27/16 at 11:38 a.m., indicated the urinary catheter bag should have been placed inside of a dignity bag. 3.1-3(t)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact			

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	with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure the resident's preferences were honored related to the number of showers requested per week for 1 of 3 residents reviewed for choices of the 6 residents who met the criteria for choices. (Resident #84) Finding includes: Interview with Resident #84 on 7/22/16 at 11:43 a.m., indicated she would like to have at least 3 showers a week. The record for Resident #84 was reviewed on 7/26/16 at 8:11 a.m. The resident's diagnoses included, but were not limited to pain, history of falling, Parkinson's disease, irritable bowel syndrome, high blood pressure, stress incontinence, and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment dated 5/25/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she had no cognitive impairments and was alert and oriented. The resident indicated it was very important to choose between a bath and shower.	F 0242	Step One: The Shower Schedule for Resident #84 was revised to ensure the resident will receive more than 2 showers per week. Step Two: The Resident Preference Sheets were reviewed for all current residents to ensure that showers are scheduled based on resident preference. Any deficiencies noted were corrected. Step Three: Nursing Staff were re-instructed on the Resident Preference Sheet and honoring resident bathing preferences. Activity Staff will now submit the Resident Preference Sheets to the DNS and/or designee upon completion to ensure proper implementation. The DNS and/or designee will randomly interview three residents or family members per unit weekly to ensure that preferences are honored. The audit findings will be reported to the QAPI Committee monthly. Step Four: The results of the Preference Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly	08/26/2016

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	The current resident information sheet indicated the resident received two showers a week on Monday and Thursday during the day. The resident bathing report sheet for the months of 5/2016, 6/2016, and 7/2016 indicated the resident had only received two showers a week with no refusals. The resident preference sheet dated 6/2016 indicated the resident preferred to have more than 2 showers per week. The preference sheet was completed by Activity Aide #1. Interview with the Memory Lane Unit Manager on 7/26/16 at 10:00 a.m., indicated she was unsure how often the preference sheets were completed but thought they were done quarterly. Interview with Activity Aide #1 on 7/26/16 at 10:12 a.m., indicated the Activity Director asked her to go around to all the residents on the Rainbow and Memory Lane Units and ask them their preferences. She indicated she had given the completed sheets back to the Activity Director and she checked off to make sure all the residents were asked. Activity Aide #1 indicated the completed forms were taken down to the appropriate			

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	units and placed in the "Big Book" on the unit. She indicated she was not sure what the "Big Book" was used for. Interview with the Memory Lane Unit Manager on 7/26/16 at 10:30 a.m., indicated the CNAs do have access to the "Big Book." 3.1-3(u)(1)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure residents were notified of new medication orders and failed to ensure a resident's Responsible Party was invited to care plan	F 0280	Step 1: 1 The Physician Order Summary was reviewed with Resident #105 to ensure that she has been informed of her current medication regimen 2 The Physician Order Summary was	08/26/2016

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	conferences for 3 of 3 residents reviewed for participation in care planning. (Residents #B, #50, and #105) Findings include: 1. Interview with Resident #105 on 7/22/16 at 10:02 a.m., indicated she was not always included in decisions about her medicine or other treatments. She also indicated that sometimes she was not notified of new medications or treatments. The record for Resident #105 was reviewed on 7/26/16 at 10:56 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, anxiety, depression, and chronic ischemic heart disease. The resident's face sheet was reviewed. The face sheet indicated the resident was her own legal representative and her nephew was emergency contact #1. The 5/3/16 Quarterly Minimum Data Set (MDS) assessment, indicated the resident's Brief Interview for Mental Status Score was "15". The resident was cognitively intact for decision making. Documentation in the Nursing Progress notes dated 5/6/16, indicated a new order		reviewed with Resident #50 to ensure that she has been informed of her current medication regimen 3. Social Services scheduled Care plan meetings for residents 105, 50 and B. Social Services will document date and attendees of care plan conference in the medical record. Step 2: 1 The medical records were reviewed for all current residents for the past 60 days to ensure appropriate resident and/or responsible party notification Any deficiencies noted were corrected 2 The medical records were reviewed for all current residents for the past 60 days to ensure appropriate resident and/or responsible party notification Any deficiencies noted were corrected 3. All residents have the potential to be affected by this practice. Residents and/or responsible parties have been and will be invited to quarterly care plan meetings by Social Services. Social Services will document date of invitation and when a care plan meeting is held. Step 3: To include 1. and 2. Licensed Nursing Staff were re-instructed regarding the policy for Notification of Change in Resident Health Status. The DNS and/or designee will audit five random medical records per unit weekly. The audit findings will be reported to the QAPI Committee monthly. 3. Executive Director or his designee will	

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	was written for as needed (prn) Zofran (a medication for nausea and vomiting). The Pharmacy and the resident's family were notified. There was no documentation to indicate the resident was notified. An entry in the Nursing Progress notes dated 5/12/16, indicated new orders were received for prn Immodium (a medication used to treat diarrhea) 2 milligrams (mg) every 6 hours as needed for loose stools. The resident's Power of Attorney (POA) and the Pharmacy were notified. There was no documentation to indicate the resident was notified. Interview with the Rainbow Unit Manager on 7/27/16 at 11:50 a.m., indicated the resident's family member, and not the resident, were notified of the medication changes in May 2016. The Unit Manager indicated the resident was her own Responsible Party. 2. Interview with Resident #50 on 7/22/16 at 9:44 a.m., indicated that she was not always included in decisions related to her medications. She indicated that she had been having recent issues related to medications and it sometimes took up to three days to be notified of new medication orders.		review weekly x 6 weeks that care plan meetings are scheduled and that invitations have been made. Step 4: To include 1 and 2 The results of the Notification Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficientpractices will be considered a trend or pattern), the results will be reviewed quarterly. 3. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly. Step 5 - These remedies will be in place by August 26, 2016.	

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	The record for Resident #50 was reviewed on 7/27/16 at 9:55 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, bipolar, anxiety, and pain. The resident's face sheet was reviewed. The face sheet indicated the resident was her own Responsible Party. The Quarterly Minimum Data Set (MDS) assessment dated 6/15/16, indicated the resident's Brief Interview for Mental Status score was "14". The resident was cognitively intact for decision making. A Physician's order dated 7/16/16, indicated the resident was to receive Risa bid probiotic 2 tablets by mouth daily for 13 days. There was no documentation of resident notification. A Physician's order dated 7/12/16, indicated the resident was to receive Lamictal (a mood stabilizer) 150 milligrams (mg) give 75 mg (1/2 tablet) daily. There was no documentation of resident notification. Interview with the Rainbow Unit Manager on 7/27/16 at 11:50 a.m., indicated documentation should have been completed to indicate the resident was aware of the medication changes.			

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	The Unit Manager indicated the resident was her own Responsible Party. 3. Interview with Resident #B's Power of Attorney (POA) on 7/22/16 at 10:39 a.m., indicated she could not remember the last time she was invited to a care plan conference. The record for Resident #B was reviewed on 7/25/16 at 8:46 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, constipation, psychosis, insomnia, Chronic Obstructive Pulmonary Disease (COPD), pain, dementia, anxiety, high blood pressure, edema, nutritional deficiency, glaucoma, peripheral vascular disease, blindness both eyes, and anemia. The Annual Minimum Data Set (MDS) assessment dated 5/25/16 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 4 indicating a severe cognition deficit and she was not alert and oriented. The current plan of care was updated 5/2016. Social Service Progress notes dated 5/26/16 indicated the annual assessment was completed. There was no information regarding the care plan conference and if the resident and the			

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	POA had been invited. Interview with the Social Service Director (SSD) on 7/26/16 at 9:15 a.m., indicated she used to send out letters for care plan meetings, but now she just informed the families in person when they visited. The SSD indicated there was no documentation of the verbal invitation. Continued interview with the SSD on 7/26/16 at 10:23 a.m., indicated there was only one documented entry in the notes regarding the resident's POA being invited to a care plan meeting and that was on 6/2/15 (last year). The SSD indicated there was also no documentation of who attended the meetings. She indicated the resident's POA was not invited to the most recent care plan meeting. 3.1-35(c)(2)(C)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and	F 0282	Step One:	08/26/2016

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	interview, the facility failed to ensure Physician Orders and/or the care plan were followed related to transfers with a gait belt, staff introduction before performing care, and checking placement of a wanderguard for 2 of 27 records reviewed. (Residents #B & #D) Findings include: 1. On 7/25/16 at 10:05 a.m., CNA #1 and the Memory Lane Unit Manager assisted Resident #B back to her room. At that time, both staff members indicated they were going reposition the resident in her high back wheelchair. They proceeded to explain the procedure to the resident, however they did not introduce themselves and give the resident their job titles prior to repositioning the resident. On 7/25/16 at 11:32 a.m., CNA #2 and CNA #3 assisted the resident back to her room. Both CNAs explained to the resident they were going to reposition her again, however they did not introduce themselves and give the resident their job titles prior to repositioning the resident. On 7/25/16 at 12:10 p.m., CNA #1 and CNA #2 pushed the resident back to her room. At that time, both CNAs explained to the resident they needed to		1.Resident #B was assessed for any injury related to transfer without a gait belt and none were noted. The gait belt was implemented for all transfers. Nursing Staff also introduced themselves by name and job title before providing care for Resident #B. 2.The wanderguard device was checked and functional for Resident #D. Step Two: 1.The DNS and/or designee observed transfers for all residents requiring use of a gait belt. Nursing Staff were also observed for introduction by name and job title. The DNS and/or designee also audited care plans for all current residents to ensure compliance with all areas of care. Any deficiencies noted were corrected. 2.All residents with current physician orders for Wanderguard Devices were tested to ensure proper functioning. The DNS and/or designee audited care plans for all current residents to ensure compliance with all areas of care. Any deficiencies noted were corrected. Step Three: 1.Nursing Staff were re-instructed on the use of gait belts per plan of care. The DNS and/or designee will visually inspect three transfers per unit weekly to ensure residents are transferred per plan of care. The	

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	check and/or change her for incontinence of bowel and bladder. The resident indicated she did not want to use the toilet, so CNA #1 explained to the resident they were going to lay her down in bed and change her. CNA #1 and CNA #2 placed their arms under the resident's armpits and instructed the resident to stand and pivot to the bed. The resident stood and pivoted towards the bed and was laid down. The CNAs did not use a gait belt during the transfer. Neither CNA introduced themselves or gave the resident their job titles prior to the transfer and incontinence care. After providing incontinence care the CNAs transferred the resident back to the high back wheelchair. During the transfer neither CNA used a gait belt. Interview with CNA #1 and CNA #2 at that time, indicated they should have transferred the resident with a gait belt. On 7/25/16 at 3:35 p.m., CNA #6 and CNA #7 assisted the resident back to her room. At that time, both CNAs explained to the resident they were going to lay her down so the nurse could do the pressure sore treatment. Neither CNA introduced themselves prior to the transfer. LPN #1 was observed changing the pressure sore dressing, however, she too, did not introduce herself prior to the		DNS and/or designee will observe five staff interactions per week with Resident #B to ensure introduction by name and job title. The audit findings will be reported to the QAPI Committee monthly. Addendum: The facility will also complete three random care plan audits per unit weekly to ensure compliance with all areas of plan of care and report findings to the QAPI Committee monthly 2.Licensed Nursing Staff were re-instructed on the procedure for testing Wanderguard Devices. The DNS and/or designee will test two Wanderguard Devices per unit weekly to ensure proper functioning. The audit findings will be reported the QAPI Committee monthly. Addendum: The facility will also complete three random care plan audits per unit weekly to ensure compliance with all areas of plan of care and report findings to the QAPI Committee monthly Step Four: The results of the Transfer,Introduction by Name/Job Title, Wanderguard, and Care Plan Audits will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considereda trend or pattern), the results will be reviewed quarterly.	

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	treatment. On 7/26/16 at 6:39 a.m., CNA #4 and CNA #5 entered the resident's room to provide morning care and get the resident out of bed. CNA #4 explained to the resident what they were going to do and offered if the resident wanted to use the toilet. Neither CNA introduce themselves prior to the transfer and morning care. After the resident was finished using the toilet, dressed and positioned in her high back wheelchair, CNA #4 then explained to the resident she was going to brush her hair. The resident stated, "Who is going to do my hair?" CNA #4 responded with her name. This was the first time the CNA introduced herself. The record for Resident #B was reviewed on 7/25/16 at 8:46 a.m. The resident's diagnoses included, but were not limited to, blindness both eyes, atrial fibrillation, constipation, psychosis, insomnia, Chronic Obstructive Pulmonary Disease (COPD), pain, dementia, anxiety, high blood pressure, edema, nutritional deficiency, glaucoma, peripheral vascular disease, and anemia. The Annual Minimum Data Set (MDS) assessment dated 5/25/16 indicated the resident's Brief Interview for Mental			

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	Status (BIMS) score was a 4 indicating a severe cognition deficit and she was not alert and oriented. The resident was coded as having hallucinations and delusions at times. The resident was an extensive assist with a two person physical assist for toilet use, dressing, and transfers. The resident was totally dependent on staff for bathing and personal hygiene. The resident was frequently incontinent of bladder and always incontinent of bowel. The resident had no natural teeth. The updated and current plan of care dated 5/2016 indicated the resident required extensive assist with transfers. Another current and updated plan of care dated 5/2016 indicated the resident had short term memory impairment with periods of increased confusion throughout the day that was complicated by her impaired vision and she misinterpreted her surroundings at times. The Nursing approaches were for staff to give the resident their names and job titles upon introduction. A Physician Order dated 6/8/15, and on the current 7/2016 Physician Order Summary indicated to assist the resident times (with) two (staff) for transfers with a gait belt.			

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	Interview with the Memory Lane Unit Manager on 7/26/16 at 6:10 a.m., indicated the resident was to be transferred with a gait belt at all times. Continued interview with the Memory Lane Unit Manager on 7/26/16 at 10:55 a.m., indicated she was unaware the resident's care plan indicated for the staff to introduce themselves and tell the resident what their job titles were before providing care. She indicated if that was on the resident's plan of care, then the staff should have been doing that. 2. On 7/27/2016 at 10:06 a.m., Resident #D was observed independently transporting herself throughout the facility by wheelchair. The record for Resident #D was reviewed on 7/26/2016 at 9:19 A.M. The resident's diagnoses included, but were not limited to, hypertension, non-Alzheimer dementia, depression, transient cerebral ischemic attack, chronic atrial fibrillation. The 14 day Minimum Data Set (MDS) assessment dated 6/23/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7 indicating the resident was severely impaired for decision making. The resident was a limited assist with one person physical			

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	assist for locomotion on the unit. The resident's care plan dated 6/20/16, indicated the resident was at risk for elopement related to exit seeking behavior. The interventions were to have a Wanderguard (identification departure alert system bracelet) in place. A Physician's Order, dated 6/17/2016 indicated Nursing staff was to check the Wanderguard every shift with the Wanderguard signaling device (a tool to ensure the Wanderguard was working properly). The TAR (Treatment Administration Record) for the month of 6/2016 indicated on 6/18, and 6/28 for the midnight shift and on 6/20 for the evening the shift the wanderguard was not signed off as being checked. The 7/2016 TAR indicated on 7/13, 7/14, 7/25, and 7/26 for the midnight shift and on 7/14 for the evening shift the wanderguard was not signed off as being checked with the signaling device. Interview with The Memory Lane Unit Manager on 7/27/16 at 10:12 a.m., indicated the nurses should have documented the checking of the Wanderguard with the signaling device on the TAR.			

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	This Federal tag relates to Complaint IN00202871. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a dialysis access site was monitored and failed to assess a resident after returning from dialysis for 1 of 1 residents reviewed for dialysis.(Resident #146) Finding includes: The record for Resident #146 was reviewed on 7/25/16 at 3:00 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and renal dialysis. A Physician's Order dated 4/23/16, indicated the resident was to receive dialysis on Mondays, Wednesdays, and	F 0309	Step One: The Treatment Administration Record was updated for Resident #146 to include documentation of an assessment of the fistula/graft site for a bruit/thrill and signs/symptoms of infection daily. Post dialysis assessments were recorded on the Dialysis Observation Communication Form for Resident #146. Step Two: All resident with current physician orders to receive Dialysis were audited to ensure proper assessment of fistula/graft site and completion of the Dialysis Observation Communication Form. Any deficiencies noted were corrected. Step Three: Licensed Nurses were re-instructed regarding the Dialysis Guideline. The DNS and/or designee will	08/26/2016

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	Fridays. A Physician's Order dated 4/25/16, indicated the resident was to have Lidocaine 4% (a medication to numb the skin) applied to the fistula (his dialysis access site) to the left arm topically one time a day on Monday, Wednesday, and Friday prior to going to dialysis. There were no further orders related to the resident's fistula. The Medication and Treatment Administration Records were reviewed for the month of July 2016. There was no documentation to indicate the resident's fistula was being assessed on a daily basis. The Dialysis Communication Book was reviewed. There were Dialysis/Observation Communication forms in the Communication Book that were to be completed at the facility prior to going to dialysis and after returning from dialysis. There were no documented assessments after returning from dialysis on the following dates: 7/25/16, 7/22/16, 7/15/16, 7/13/16, 7/11/16, 7/8/16, 7/6/16, 7/4/16, 7/1/16, 6/29/16, and 6/24/16. The next Communication form was dated		audit the medical record of two resident receiving dialysis per unit weekly to ensure proper fistula/graft site assessment and completion of the Dialysis Observation Communication Form. The audit findings will be reported to the QAPI Committee monthly. Step Four: The results of the Dialysis Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without anytrends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	6/17/16. Interview with RN #1 on 7/26/16 at 2:55 p.m., indicated prior to the resident going out to dialysis, she checked the resident's vitals (heart rate, respiration rate & blood pressure) and checked his fistula for bruit (listening to the fistula) or feel for thrill (by touching the fistula.) About an hour prior to the resident going out, she applied Lidocaine cream to the fistula site and covered it with saran wrap. She also assessed the fistula site for discoloration and any bleeding due to the resident being a "picker." The RN indicated this was documented on the dialysis communication sheet that goes with the resident. The RN indicated on non-dialysis days, the fistula was assessed and would be charted on only if something is wrong. Interview with the Rainbow Unit Manager on 7/27/16 at 2:45 p.m., indicated a treatment sheet should have been initiated related to monitoring the resident's fistula. She also indicated an assessment was to be completed when the resident returned from dialysis. The Dialysis Guideline policy was reviewed on 7/27/16 at 12:55 p.m. The policy was provided by the Restorative Nurse and identified as current. The Post			

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	Dialysis Protocol indicated the fistula was to be checked for bruit (listening to fistula) or feel for a thrill (by touching the fistula.) This must be done daily, best after the dressing is removed. Documentation on Treatment sheets includes: Fistula checks daily: Monitoring for presence of bruit and thrill and check for signs/symptoms of infection daily. 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure a resident who was totally dependent on staff for Activities of Daily Living (ADLs) was provided the assistance needed related to oral and incontinence care for 2 of 3 residents reviewed for ADLs of the 55 residents who met the criteria for ADLs. (Residents #B & #C) Findings include:	F 0312	Step One: 1.Incontinence care was provided, oral care offered with AM Care, and care plan/CNA care sheet were updated for Resident#B. 2.Incontinence care was provided and care plan/CNA care sheet were updated to indicate the resident is to have incontinence care provided every two hours for Resident #C. Step Two: All residents who are dependent on staff for Activities of Daily Living were visually	08/26/2016

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	1. Interview with Resident #B's Power of Attorney (POA) on 07/22/16 at 10:27 a.m., indicated she did not believe her mom was taken to the bathroom on a regular basis. She further indicated she did not think her mom's teeth were brushed every day, because they were always very dirty when she cleaned them at night. On 7/25/16 at 10:05 a.m., CNA #1 and the Memory Lane Unit Manager assisted Resident #B back to her room. At that time, both staff members indicated they were going reposition the resident in her high back wheelchair. The CNAs did not check the resident for incontinence. On 7/25/16 at 11:32 a.m., CNA #2 and CNA #3 assisted the resident back to her room. Both CNAs explained to the resident they were going to reposition her again. The CNAs did not check the resident for incontinence. On 7/25/16 at 12:10 p.m., CNA #1 and CNA #2 pushed the resident back to her room. At that time, both CNAs explained to the resident they needed to check and/or change her for incontinence of bowel and bladder. The resident indicated she did not want to use the toilet, so the CNA #1 explained to the resident they were going to lay her down		observed for appropriate incontinence and oral care. Any deficiencies noted were corrected. Step Three: Nursing Staff were re-instructed on providing incontinence care every two hours and oral care with AM and PM care. The DNS and/or designee will observe incontinence and oral care for five random residents per unit weekly. The audit findings will be reported to the QAPI Committee monthly. Step Four: The results of the Incontinence and Oral Care Observation Audits will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considereda trend or pattern), the results will be reviewed quarterly.	

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	in bed and change her. The resident's incontinent brief was saturated with strong smelling urine. Interview with CNA #1 at that time, indicated she had checked the resident had 9:00 a.m., for incontinence, at which time she was dry. The CNA indicated she had not checked or changed her since 9:00 a.m. CNA #1 indicated "We are supposed to check and change the residents every two hours." On 7/26/16 at 6:39 a.m., CNA #4 and CNA #5 entered the resident's room to provide morning care and get the resident out of bed. CNA #4 explained to the resident what they were going to do and offered if the resident wanted to use the toilet. After the resident was finished using the toilet, dressed and positioned in her high back wheelchair, CNA #4 then explained to the resident she was going to brush her hair. After brushing the resident's hair, CNA #5 pushed the resident out of the room and seated her wheelchair by the bird cage. Neither CNA offered to or provided oral care for the resident. The record for Resident #B was reviewed on 7/25/16 at 8:46 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, constipation,			

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	psychosis, insomnia, Chronic Obstructive Pulmonary Disease (COPD), pain, dementia, anxiety, high blood pressure, edema, nutritional deficiency, glaucoma, peripheral vascular disease, blindness both eyes, and anemia. The Annual Minimum Data Set (MDS) assessment dated 5/25/16 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 4 indicating a severe cognition deficit and she was not alert and oriented. The resident was coded as having hallucinations and delusions at times. The resident was an extensive assist with a two person physical assist for toilet use, dressing, and transfers. The resident was totally dependent on staff for bathing and personal hygiene. The resident was frequently incontinent of bladder and always incontinent of bowel. The resident had no natural teeth. The updated and current plan of care dated 5/2016 indicated the resident required extensive assist with transfers, dressing, eating, and bed mobility. There was no care plan indicating the resident's daughter was the only person to brush the resident's teeth. A bowel and bladder assessment dated			

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	5/25/16 indicated the resident was incontinent of bowel and bladder. The resident was not on a toileting schedule. Interview with the Memory Lane Unit Manager on 7/26/16 at 6:10 a.m., indicated the resident was to be checked and changed for incontinence at least every two hours. Interview with CNA #4 on 7/26/16 at 11:00 a.m., indicated she did not brush or offer to brush the resident's teeth because her daughter did it at night and preferred it that way. Interview with CNA #5 on 7/26/16 at 11:08 a.m., indicated she did not offer to or brush the resident's teeth during morning care, because the resident would yell and the daughter did it at night. She further indicated the daughter preferred to do it herself. Interview with the Memory Lane Unit Manager on 7/26/16 at 11:20 a.m., indicated there was no current plan of care to indicate the resident's daughter was to provide oral care. She further indicated she was unaware what the daughter's preference was regarding the cleaning of her mom's dentures. 2. On 7/25/16 at 9:15 a.m., Resident #C was observed in the hallway by the			

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	Nurse's station watching the birds. At 11:27 a.m. the resident was observed being taken by a staff member to get her nails polished. At 11:56 a.m. the resident was returned to the hallway by the nurses station to watch the birds. During the above times the resident was not checked for incontinence care by any staff member. Interview with CNA # 8 at 11:58 a.m., indicated the resident was not on an incontinence care program to check and change every two hours. She further indicated the resident usually changes herself. At 12:08 p.m., CNA #8 took the resident to her room to check for incontinence. The resident's brief was soaked with urine and stool. The CNA indicated her brief needed to be changed. The resident was unable to stand up from the wheelchair without assist or change herself. At that time, the CNA indicated she believed the last time the resident had been checked was after breakfast at 9:00 a.m. Interview with The Rainbow Unit			

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	Manager on 7/26/16 at 12:51 p.m., indicated the facility had a protocol for incontinence care. If residents were dependent, the staff should check them at least every two hours. The resident was on an incontinence care program. The resident should have been checked within the three hours, and assisted to the bathroom. The record for Resident #34 was reviewed on 7/25/16 at 1:54 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, Huntington disease, major depressive disorder, obesity, and sleep disorder. The 5 Day Minimum Data Set (MDS) assessment dated 4/27/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating she was moderately impaired for decision making and not alert and oriented. The resident needed supervised assist with one person physical assist for transfers, toileting, and personal hygiene. The resident was occasionally incontinent of urine and always continent of bowel, and was not on any toileting program. The 8/2014 plan of care indicated alteration in elimination of bladder incontinence. The Nursing approaches were to provide the resident with			

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	incontinence care with the check and change program, and to monitor and report any changes in ability to toilet, or changes in continence status. Review of the Incontinence Management/Bladder Function Guideline, #CLIN 180, version #4, effective date 6/9/15, ..."Absorbent Products/External Collection Devices - If the resident is cognitively impaired and is unsuccessful at toilet training or is unable to participate in retraining then the resident should be placed on an incontinence care program". This policy was received from the Director of Nursing (DON) on 7/27/16 at 3:50 p.m., who indicated it was the most current policy. Interview with the DON on 7/27/2016 at 3:56 p.m., indicated the incontinence care program was to check the residents every two hours for incontinence, and if soiled perform incontinence care. This Federal tag relates to Complaint IN00202871. 3.1-38(a)(2)(C) 3.1-38(a)(3)(C)			

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F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastronomy (PEG) tubes received the necessary care and treatment related to proper medication administration for 1 of 1 resident reviewed for PEG-tubes. (Resident #155) Finding includes: On 7/25/16 at 12:21 p.m., LPN #2 was observed preparing medications for Resident #155. The LPN dispensed one pill from it's plastic packaging and placed it into a plastic cup and proceeded to crush the medication.	F 0322	Step One: Resident #155 was checked for residual tube feeding and assessed for any adverse effects to the medication not being dissolved in water prior to administration. Step Two: All residents with current physician orders for enteral tube feeding were checked for residual and any adverse effects to medications not being dissolved prior to administration. No deficiencies were noted. Step Three: Licensed Nursing Staff were re-instructed on the Enteral Tube Medication Policy. The DNS and/or designee will visually observe checking for residual and administration of medication via enteral tube for two random residents per unit weekly. The	08/26/2016

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	After entering the resident's room, the LPN donned clean gloves and was observed turning off the resident's tube feeding. She disconnected the tube feeding, listened for bowel sounds, and flushed the tubing with 30 milliliters (ml) of water. She then poured the dry powdered medication into the syringe followed by 10 ml of water. The LPN did not dissolve the medication with water prior to administration nor did she check the resident's stomach for tube feeding residual. Once the medication was administered the LPN then flushed the resident's tubing with 30 ml of water and resumed the tube feeding. Interview with LPN #2 at the time indicated she always administers medications via the PEG-tube in that manner and had checked for residual earlier that morning. The record for Resident #155 was reviewed on 7/26/16 at 2:49 p.m. The resident's diagnoses included, but were not limited to, dysphagia (a swallowing disorder) and quadriplegia (partial or total loss of use of all four limbs). The current and updated Care Plan dated 2/4/16 indicated the resident was dependent on tube feeding. The		audit findings will be reported to the QAPI Committee monthly. Addendum: The visual observations will include observations on all shifts Step Four: The results of the Enteral Tube Medication Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	interventions included, but were not limited to, medications via the PEG-tube as ordered. Review of the current Enteral Tube Medication policy dated 11/2011, provided by the Administrator on 7/25/16 at 2:30 p.m. and deemed as current, indicated "Crush immediate release tablets into a fine powder, and dissolve in 5-10 ml of warm water, or prescribed amount." Further review of the policy also indicated, "Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100 ml." Interview with the Director of Nursing on 7/25/16 at 3:45 p.m., indicated the nurse should have checked for residual prior to administering the medication and the medication should have been dissolved in water prior to the administration. 3.1-44(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, record review, and interview, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents related to ensuring a resident was properly transferred with a physical two person assist while being transferred with a Marisa Lift (a lifting/transferring device) for 1 of 4 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Resident #136) Finding includes: On 7/23/16 at 5:42 p.m., CNA #9 was observed transferring Resident #136. The resident was being transferred via a Marisa Lift from her bedroom into her wheelchair which was positioned in the hallway. The CNA exited the resident's room with the resident anchored in the air. The CNA propelled the lift into the hallway where the resident's daughter was standing behind the wheelchair. The CNA made multiple failed attempts to lower the resident into her wheelchair unassisted, the resident's daughter was observed assisting the CNA with positioning the resident's wheelchair underneath her, the resident was then lowered into the chair. The record for Resident #136 was reviewed on 7/25/16 at 9:25 a.m. The	F 0323	Step One: Resident #136 was assessed for any injury related to transfer via mechanical lift with one person assistance. No injuries were noted. Step Two: All residents who are care planned of use of a mechanical lift for transfers were visually observed to ensure two person assistance during transfers. No deficiencies were noted. Step Three: Nursing Staff were re-instructed on use of two person assistance with mechanical lift transfers. The DNS and/or designee will visually observe three random mechanical lift transfers per unit weekly. The findings will be reported to the QAPI Committee monthly. Addendum: The visual observations will include observations on all shifts Step Four: The results of the Mechanical Lift Observation Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly	08/26/2016

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	resident's diagnoses included, but were not limited to, paraplegia, anxiety, and hypertension. The Annual Minimum Data Set (MDS) assessment dated 6/24/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately impaired for decision making and had some cognitive impairment. The resident was an extensive physical two person assist for transfers. The resident had no history of falls since the last assessment. The current and updated Care Plan dated 6/22/15 indicated the resident was at risk for falls. The intervention included but were not limited to, assess for need to have wheelchair locked/unlocked for safety. Review of the CNA Care Card dated 7/14/16 indicated the resident was a two person assist with transfers via the Marisa Lift. The resident was to have a two staff assist when given any kind of care. Interview with CNA #9, at the time, indicated the resident should have been transferred with a two staff assist. Interview with Director of Nursing on 7/23/16 at 6:10 p.m., indicated the CNA			

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	155136	A. BUILDING 00 B. WING	07/27/2016

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	should not have transferred the resident from the privacy of her bedroom into the hallway by the lift and into her wheelchair without the assistance of a second staff member present. 3.1-45(a)(2)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post the Scheduled Nurse Staffing sign with the correct information related to the time frame for actual hours worked for 3 of 3 Units of the 3 Units in the facility. (A, B, and C Units) Finding includes: 1. On 7/21/16 at 8:30 am, 7/22/16 at 8:30 a.m., 7/23/16 at 6:00 p.m., 7/25/16 at 8:30 a.m., 7/26/16 at 8:30 a.m., and 7/27/16 8:30 a.m., the Nurse staffing sign indicated the incorrect information. The posted sign did not display the time frame for the actual hours worked for each shift. Interview with the Administrator on 7/27/16 at 3:25 p.m., indicated he was not aware the time frame for the actual hours worked was to be indicated on the staffing sign. 3.1-17(a)	F 0356	Step One: The Nursing Staffing Information Sheet was revised to include the shift times for RN, LPN, and CNA shifts. Step Two: The DNS visually inspected the revised Nursing Staffing Information Sheet for five consecutive days to ensure proper posting of Nursing Staffing Hours. Any deficiencies noted were corrected. Step Three: The Nursing Scheduler was re-instructed on the use of the revised Nursing Staffing Information Sheet. The DNS and/or designee will visually inspect the Nursing Staffing Information Sheet three times weekly to ensure proper posting of Nursing Staffing Hours. The audit findings will be reported to the QAPI Committee monthly. Step Four: The results of the Nursing Staff Posting Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	08/26/2016
F 0363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN			

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Bldg. 00	ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure recipes were followed related to 1 of 1 observations of puree vegetable preparation. This had the potential to affect the 15 residents who received a pureed diet in the facility. Finding includes: On 7/27/16 at 10:35 a.m., Dietary Cook #1 was preparing puree cream corn. The Cook poured the can of cream corn into the food processor. She indicated she used a #10 can of creamed corn to make 15 pureed servings. The Cook proceeded to turn on the blender and blend the corn. The Cook indicated she was adding 1 cup of thickener to the mixture due to it being "runny". After adding the thickener, the Cook blended the mixture again and let it sit for a minute. The Cook indicated she was adding an additional 2/3 cup of thickener to the mixture because it wasn't "quite right yet." After adding the mixture she blended the corn again and let it set. She indicated she was adding	F 0363	Step 1 – No residentswere identified as being directly affected by this practice. . Step 2 – All residents who have an altered diet are potentially affected by this practice. Food Preparation staff will be re-educated regarding food preparation techniques, following recipes to ensure proper consistency. Step 3 – Dining Services Manager will complete in-service training on food preparation, and following recipes to ensure proper preparation of all diets. Step4 – Dining Services Manager or her designee will audit 3 x weekly x 6 weeks , including each meal (breakfast,lunch, and dinner) to ensure recipes are followed. The results of these audits will be reviewed in the Managers Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern)the results will be reviewed quarterly. Step 5 - These remedies will be in place by August 26, 2016.	08/26/2016

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	another 1/3 cup of thickener, which would be 2 cups total of thickener. The Cook indicated that she added the thickener until it looked like the proper consistency. The pureed creamed corn recipe was reviewed at the time. The recipe indicated 1/3 cup of instant thickener was to be added rather than 2 cups. Interview with the Dietary Food Manager at the time, indicated the recipe should have been followed as written. 3.1-20(i)(4)			
F 0364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure foods were served at the proper temperature for 2 of 2 observations of food temperatures taken. (The Main Kitchen and Memory Lane test tray) Findings include:	F 0364	Step 1 – No residents were identified who were affected by this practice. Step 2– All residents who receive meals from Dining Services are potentially affected by this practice. Food Preparation staff will be re-educated regarding food temperature guidelines. Step 3 – Dining Services Manager will complete in-service education to	08/26/2016

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	1. On 7/26/16 at 12:30 p.m., the following food temperatures were taken from the tray line by the Dietary Food Manager (DFM): Chicken breast 138 degrees Fahrenheit Sweet potatoes 136 degrees Fahrenheit Puree chicken 138 degrees Fahrenheit Mashed potatoes 138 degrees Fahrenheit Interview with the DFM at the time, indicated heated pellets were used for the trays that went down to the units. She also indicated temperatures had been taken earlier at the start of the tray line but they weren't documented. Interview with the DFM on 7/27/16 at 3:15 p.m., indicated she would have expected the temperature of the chicken and the potatoes to be warmer on the tray line. 2. On 7/27/16 at 12:42 p.m., a test tray was delivered to the Memory Lane Unit. At 12:44 p.m., the temperature of the corn was 126 degrees Fahrenheit. Interview with the Dietary Food Manager (DFM) on 7/27/16 at 3:15 p.m., indicated the corn was 180 degrees on the tray line. She indicated the corn should have been warmer when it reached the unit.		Dining Services staff on proper food temperatures and logging food temperatures prior to serving. Step 4 –Dining Services Manager or designee will audit to ensure food will be temped and logged prior to service beginning for each meal. Test trays will be temped following last resident tray being served 5 x weekly x 6 weeksto ensure proper food temperatures. This audit will include all 3 meal times. The results of these audits will be reviewed in the Managers Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trendsor patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly. Step 5 - These remedies will be in place by August 26, 2016.	

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	The Holding and Serving policy was reviewed on 7/27/16 at 4:07 p.m. The policy was provided by the Dietary Food Manager and identified as current. The policy indicated to hold hot foods at a continuous temperature of 140 degrees Fahrenheit or above on the serving line or according to state regulations. Reheat immediately to 165 degrees Fahrenheit for 15 seconds any hot food that falls below 140 degrees Fahrenheit - discard any food reheated at the end of service. This Federal tag is related to Complaint IN00202871. 3.1-21(a)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions related to food opened and not	F 0371	Step 1- The deficiencies identified during the survey were corrected. Step 2- The entire kitchen area was inspected for areas in need of cleaning, or repair. Any issues	08/26/2016

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	dated and an accumulation of dust and debris in food preparation areas. (The Main Kitchen) Findings include: 1. On 7/21/16 at 8:45 a.m., during the Brief Kitchen Tour with the Dietary Food Manager, the following was observed: a. There was an accumulation of dust around the ceiling vents and on the ceiling above the reach-in cooler and freezer, as well as above the walk-in refrigerators and freezers. b. A bag of french fries in the reach-in freezer was opened and not dated. There was also a bag of chicken tenders in the reach-in freezer that was opened and not dated. 2. On 7/27/16 at 10:40 a.m., during the Full Kitchen Tour with the Dietary Food Manager, the following was observed: a. Four trays of cooked green peppers were stacked on a plastic cart and uncovered. Flies and gnats were observed in the area. b. The oven hood lights and pipes had an accumulation of dust and grease.		identified were corrected. Step 3- The Executive Director or designeewill complete sanitation rounds weekly. Issues identified will be corrected. Step 4- The results of the Sanitation Rounds will be reviewed in the Managers Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly. Step 5 - These remedies will be in place by August 26, 2016.	

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	c. The plastic cart that contained the tray covers had an accumulation of dried food spillage. d. The shelf which housed the pans underneath the food preparation counter had an accumulation of food debris. Interview with the Dietary Food Manager at the time, indicated all of the above were in need of cleaning. The Storage of Frozen Foods policy was provided by the Dietary Food Manager on 7/27/16 at 4:07 p.m. The policy was identified as current. The policy indicated to properly re-seal packages of frozen foods that have been opened to prevent freezer burn and spoilage. 3.1-21(i)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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	(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure wash basins, urinals, and bed pans were stored properly for 3 of 3 units. The facility also failed to properly dispose of lancets, needles, soiled gloves, dressings and linens for 1 of 2 pressure ulcer treatments observed and for 1 of 1 insulin injection observed. (Residents #B and #48 and the Memory Lane, Rainbow Lane, and Terrace Gardens units)	F 0441	Step One: 1.The resident's floor was cleansed and Resident #B was assessed for any adverse effects related to the dressing change procedure. 2.To include all residents/rooms cited: The bedpans, urinals, wash basins, and denture cups were sanitized, bagged, and stored appropriately. 3.The lancets and needle were disposed of in a sharps container. Step Two: 1.The DNS observed five	08/26/2016

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	Findings include: 1. On 7/25/16 at 3:35 p.m., LPN #1 was observed performing a pressure ulcer treatment for Resident #B. The LPN washed her hands with soap and water and donned a clean pair of gloves to both of her hands. She removed the foam dressing from the resident's coccyx and threw the bandage on the floor. She removed her gloves and threw them on the floor as well. She donned another pair of gloves to both of her hands and cleaned the area with wound cleanser and a wash cloth. After she had cleaned the open area, she threw the wash cloth on the floor. The LPN opened the Venelex (a medicated) ointment and applied a large amount to her gloved finger and spread the ointment with her finger onto the wound. The LPN covered the wound and removed her gloves. Interview with LPN #1 at that time, indicated she should not have thrown the soiled foam pad, gloves and washcloth on the floor. She further indicated she should have used a Q-tip applicator to apply the Venelex ointment to the wound and not her finger. Interview with Director of Nursing on 7/27/16 at 2:30 p.m., indicated LPN #1 should not have placed the soiled items		random dressing changes to ensure proper completion of the procedure. Any deficiencies noted were corrected. 2.The DNS completed a facility tour to observe for proper bedpans, urinals, wash basins, and denture cup storage. Any deficiencies noted were corrected. 3.The DNS observed five random blood glucose testing and insulin administration to ensure appropriate disposal of lancets and needles. No deficiencies were noted. Step Three: 1.Licensed Nursing Staff were re-instructed on the Clean Dressing Change Procedure. The DNS and/or designee will observe three random dressing changes per unit weekly. The audit findings will be reported to the QAPI Committee monthly. 2.Nursing Staff were re-instructed on proper sanitization, bagging, and storage of bedpans, urinals, wash basins, and denture cups. The DNS and/or designeewill conduct a facility tour two times weekly to ensure proper storage Personal Items such as bedpans, urinals, wash basins, and denture cups. The audit findings will be reported to the QAPI Committee monthly. 3.Licensed Nursing Staff were re-instructed on the Needle Handling and Disposal Policy. Sharps Containers were installed in all resident	

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	on the floor and should have used a Q-tip applicator to apply the ointment. The current 3/2009 Clean Dressing Change Audit policy provided by the Director of Nursing on 7//27/16 at 3:20 p.m., indicated place a plastic bag at the end of the bed for discarding soiled materials. Apply prescribed medication using a clean tongue blade or Q-tip. Use separate tongue blade or Q-tip to each area. Remove gloves when finished and place into plastic bag. 2. During the Environmental tour on 7/27/16, from 12:30 p.m. to 1:42 p.m., with the Housekeeping/Laundry Supervisor, the Maintenance Supervisor and the Administrator, the following was observed: Memory Lane a. There was a bed pan on the floor in the closet in room 206. There was one resident who resided in the room. b. There was an empty urinal on the floor in room 211. There was one resident who resided in the room. Rainbow Lane: a. There were wash basins and a bed pan		bathrooms. The DNS and/or designee will visually observe three random blood glucose testing procedures with insulin administration per unit weekly to ensure proper disposal of lancets and/or needles. The audit findings will be reported to the QAPI Committee monthly. Addendum: The visual observations will include observations on all shifts Step Four: The results of the Clean Dressing Change, Personal Items, and Needle Disposal Audits will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficientpractices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	on the floor in the closet in room 30. The items were not stored in a plastic bag. There were 2 residents who resided in the room. b. There was an uncovered wash basin on the top shelf in the closet in room 19. There were 2 residents who resided in the room. c. There was an uncovered wash basin on the top shelf in the closet in room 5. There were two residents who resided in the room. d. There was an uncovered wash basin on the top shelf of the closet in room 17. There were two residents who resided in the room. e. There was an uncovered wash basin in a chair in the resident's shower in room 1. There was one resident who resided in the room. f. There was an uncovered wash basin on the top shelf of the closet in room 26. There were two residents who resided in the room. g. There was an uncovered wash basin on the top shelf of the closet in room 7. There were two residents who resided in the room.			

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	Terrace Gardens a. There was an uncovered wash basin on the top shelf of the closet in room 107. There were 2 residents who resided in the room. b. There uncovered wash basins stored in the bed side storage cart in room 110. There were 2 residents who resided in the room. c. There was an uncovered denture cup on the back of the toilet and an uncovered wash basin on the closet shelf in room 115. There were 2 residents who resided in the room and 2 residents who shared the bathroom. d. There was an uncovered denture cup on the back of the toilet in room 123. There was also an urinal hanging on the rail in the bathroom. There were 2 residents who shared the bathroom. e. There was an uncovered wash basin on the top shelf of the closet in room 120. There were two residents who resided in the room. f. There was a denture cup on the back of the sink and an uncovered wash basin on the top shelf of the closet in room 115.			

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	There were 2 residents who resided in the room and two residents who shared the bathroom. h. There was an uncovered wash basin on the top shelf of the closet in room 121. There were two residents who resided in the room. Interview with the Housekeeping/Laundry and Maintenance Supervisors on 7/27/16 at 1:42 p.m. indicated it was the responsibility of the Nursing staff to contain and cover the wash basins, urinals, and bed pans. Interview with the Director of Nursing on 7/27/16 at 2:30 p.m., indicated the wash basins, bed pans, and urinals should not be stored on the floor or on the closet shelves. She further indicated they should be stored in plastic bags. The current 2009 Bedpan/Urinal policy provided by the Director of Nursing on 7/27/16 at 3:20 p.m., indicated bedpans and urinals were not to be placed on the floor or in the bedside stand. 3. On 7/25/16 at 11:45 a.m., the Terrace Gardens Unit Manager was observed performing an Accucheck (blood glucose test) for Resident #48. After entering the resident's room, the Unit Manager was observed donning clean gloves. She then			

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	proceeded to perform the blood testing, pricked the resident's finger with a lancet (needle) and disposed of it into the resident's bedside trash can. She then squeezed the resident's finger to obtain the blood sample, however, the battery to the blood testing device died. She removed her gloves and walked out of the resident's room and into the hall to get another device. The Unit Manager then came back into the room with another device and repeated the blood testing. She was again observed disposing of the second lancet into the resident's bedside trash can. After the monitoring the results, the resident required Insulin (a medication to lower blood sugar levels) coverage. The Nurse Manager then placed the disposable needle on the Insulin Kwik-Pen, administered the medication, and disposed of the needle into the resident's bedside trash can. Review of the current Needle Handling and Disposal policy dated 8/2012, provided by the Administrator on 7/25/16 at 2:30 p.m., indicated "Do not discard used or unused needles into trash receptacles. Interview with the Unit Manager, at the time, indicated she did not properly dispose of the two lancets nor did she			

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	properly dispose of the needle. They should have been disposed in the sharps container located on the side of the medication cart. Interview with the Director of Nursing on 7/25/16 at 3:45 p.m., indicated the Unit Manager should have disposed of two lancets and the needle into the sharps container per facility policy. 3.1-18(b)(1) 3.1-18(l)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to an accumulation of dust and grease, dried food spillage, chipped paint, marred walls and closet doors, chipped paint on heat registers, dust on fan blades, bugs in light fixtures, leaky faucets and a loose baseboard in 1 of 1 Kitchen areas and on 3 of 3 units throughout the facility. (The Main Kitchen, Memory Lane, Terrace Gardens, and Rainbow Lane) Findings include:	F 0465	Step 1- The deficiencies identified during the survey were corrected. Step 2- The entire living center was inspected for need of cleaning, repair or repainting. Any issues identified were corrected. Step 3- Staff members were re-educated to the use of the Building Engines System to report repair needs. Housekeeping and Maintenance staff were re-educated the importance of completing routine maintenance and housekeeping rounds. The Executive Director or designee will complete environmental rounds weekly. Issues identified	08/26/2016

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	1. During the Brief Kitchen Tour on 7/21/16 at 8:45 a.m., with the Dietary Food Manager, the following was observed: a. There was chipped paint underneath the oven hood. b. There was an accumulation of grease and debris on floor in between the fryer and oven. c. There was an accumulation of dirt and debris along the baseboard behind the oven and the fryer. 2. During the Full Kitchen Tour on 7/27/16 at 10:40 a.m., with the Dietary Food Manager, the following was observed: a. There was an accumulation of dirt and debris on the floor behind the oven and along the baseboard. b. There was an accumulation of grease on the floor and on the side of the steamer next to the fryer. c. The gray pipes located underneath the food preparation table had an accumulation of dried food spillage.		will be corrected. Step 4- Executive Director or his designee will conduct environmental rounds weekly x 6 weeks. The results of the Environmental Rounds will be reviewed in the Managers Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly. Step 5 - These remedies will be in place byAugust 26, 2016.	

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	d. The window sill next to the food processor had an accumulation dried food spillage. e. There was an accumulation of dust and grease on top of the convection oven. f. A yellow soap residue was observed on the wall next to the handwashing sink. The Dish Room a. There was an accumulation of dust on the fan blades on the fan located on the wall. b. The baseboard throughout the dish room had an accumulation of dirt and debris. Interview with the Dietary Food Manager at the time, indicated all of the above were in need of cleaning. 2. During the Environmental tour on 7/27/16, from 12:30 p.m. to 1:42 p.m., with the Housekeeping/Laundry Supervisor, the Maintenance Supervisor and the Administrator, the following was observed: Memory Lane: a. The walls were marred by the bathroom door in room 206. There was			

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	one resident who resided in the room. b. The over the toilet seat was rusty in room 215. There were two residents who shared the bathroom. c. The wall behind the toilet was marred in room 213. There was one resident who used the bathroom. d. The walls were marred by the resident's bed in room 218. There were two residents who resided in the room. e. There were dead insects observed in the light fixtures above the Nurse's station. Rainbow Lane: a. The closet door was marred in room 30. There were two residents who resided in the room. b. The walls were marred and scuffed in room 28. There was one resident who resided in the room. c. The closet door was marred in room 5. The walls next to the bed and behind the head of the bed were marred. There were two residents who resided in the room. d. The walls were chipped with paint			

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	behind the recliner in room 11. The bathroom walls were marred. The faucet was leaking in the bathroom and the air conditioner frame was marred. There were two residents who resided in the room and two residents who shared the bathroom. e. The paint was peeling away from the wall by the side of the bed in room 1. There was one resident who resided in the room. f. The walls were marred in room 7. The floor tile in the bathroom was cracked. The closet door was marred. There were two residents who resided in the room and two residents who shared the bathroom. g. The walls were marred by the resident's bed in room 26. The plaster was buckled behind the toilet. There were two residents who resided in the room and two residents who shared the bathroom. h. The walls were marred in room 23. The air conditioning unit was marred and scuffed. The closet door was off the track. There were two residents who resided in the room and two residents who shared the bathroom.			

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	i. The plastic trim on the night stand was missing in room 9. The baseboard in the bathroom was dented inwards. There was one resident who resided in the room and one resident who used the bathroom. Terrace Gardens a. The closet door was gouged in room 107. There were two residents who resided in the room. b. The over the toilet seat was rusty in room 110. There were two residents who shared the bathroom. c. The walls were marred behind the book case in room 129. There was dried feces on the toilet seat and seat riser in the bathroom. There were two residents who resided in the room and two residents who shared the bathroom. d. The walls were marred in room 113. There were 2 residents who resided in the room e. The ceiling was gouged in the bathroom in room 112. There were two residents who shared the bathroom. Interview with the Housekeeping/Laundry and Maintenance Supervisors on 7/27/16 at 1:42 p.m.			

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	indicated all the above was in need of cleaning and/or repair. 3.1-19(f)			