STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING 00 B. WING	04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey-Immediate Jeopardy. This visit included a State Residential Licensure Survey. Survey dates: April 17, 18, 19, and 20, 2016 Extended Survey dates: April 21 and 22, 2016 Residential Survey date: April 25, 2016 Facility Number: 0001120 Provider Number: 155758 AIM Number: 200525120 Census Bed Type: SNF/NF: 43 Residential: 54 Total: 97 Census Payor Type: Medicare: 4 Medicaid: 39 Total: 43 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000		

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

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	16.2-3.1. Q.R. completed by 14466 on May 02, 2016.			
F 0156 SS=D Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.			

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

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	requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure residents received a financial liability notice 48 hours prior Medicare non-coverage for skilled services for 2 of 3 residents reviewed for discontinued benefits (Residents #21 and #26). Findings include: 1. Resident #21's record was reviewed on 04/19/2016 at 3:32 p.m. An admission record, dated 01/18/2016, indicated Resident #21's spouse was the responsible party. A Minimum Data Set (MDS) assessment, dated 04/04/2016, indicated the resident was cognitively intact and had a Brief Interview for Mental Status (BIMS) score of 13 of 15. An undated Advance Beneficiary Notice of Noncoverage (ABN) indicated, "...We expect Medicare may not pay for the D.	F 0156	F 0156 SS=D ·A spreadsheet has been created to track ABN notices. (See exhibit A) ·A Policy & Procedure and spreadsheet to track the ABN notices has been created. (See exhibits A & B) · Staff Re-education completed and Policy & Procedure in place. (See exhibit B) Per policy, the notice will be provided two calendar days in advance of Medicare benefit ending. ·The Tracking spreadsheet will be monitored daily by the Business Office Manager for 3 months, then weekly thereafter. The form will be updated as needed based on daily morning meetings, weekly Medicare meetings and receipt/mailing of notices. ·The changes will be completed no later than May 25, 2016.	05/25/2016

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	Sp, PT & OT [speech therapy/physical therapy/occupational therapy]...." The notice indicated the resident would discharge from speech therapy on 02/04/2016, due to refusals and indicated PT and OT would continue. The notice was not signed by Resident #21 or their spouse and did not indicate options regarding appeal or desire to continue receiving non-covered service. A Speech Therapy (ST) Discharge Summary, dated 1/21/16-2/4/16, indicated Resident #21's ST was discontinued due to, "Highest practical level achieved." An undated Advance Beneficiary Notice of Noncoverage (ABN) indicated, "...We expect Medicare may not pay for the D. PT/OT [physical therapy/occupational therapy]...." The notice indicated the resident would discharge from PT (Physical Therapy) on 04/01/2016, and from OT on 4/11/16, due to the highest levels being achieved. The notice was signed by Resident #21, but did not include a date of the resident's signature and did not indicate options regarding appeal or desire to continue receiving non-covered service. A facility letter, dated 03/30/2016, indicated, "...Medicare does not pay for			

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	all of your health costs...Right now, in your case Medicare probably will not pay for--Items of Services: Skilled Because: Last day of Medicare 4/11/206 (sic)... [handwritten]." The notice was signed by the resident's spouse on 4/7/16. During an interview on 04/20/2016 at 10:20 a.m., Occupational Therapist #1, indicated therapy staff verbally inform residents services will be discontinued after the 3rd refusal of therapy in a row. She indicated there was no documentation to communicate pending discharge, but indicated the facility was "usually informed" of planned discharges a week before services ended during the "morning meeting." The therapist indicated the facility met weekly on Wednesdays to discuss potential discharges and sent emails prior to discharge to communicate services that would be discontinued. The OT provided a copy of a "Census Details Report," dated 3/29/2016, that was emailed to the facility on 3/29/16 at 3:48 p.m., indicating Resident #21's PT would discontinue on 4/1/16, and OT would discontinue on 4/11/16. 2. Resident #26's record was reviewed on 4/19/16 at 3:50 p.m. An admission record, dated 11/2/2015, indicated the resident's daughter was the responsible			

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	party. A MDS (Minimum Data Set) assessment, dated 2/9/16, indicated the resident was cognitively intact and had a BIMS (Brief Interview for Mental Status) score of 15 of 15. A Speech Therapy discharge summary, with dates of service from 1/14/2016-2/4/2016, indicated the reason for discontinuation of services was, "All Goals Met." An ABN (Advanced Beneficiary Notice) for discontinuation of ST (Speech Therapy) was not located in the record and was not provided when all ABN's for the past 6 months were requested for review. An undated ABN indicated OT (Occupational Therapy) would discontinue on 03/08/2016. The notice was signed by Resident #26's Power of Attorney (POA) on 04/19/2016. An undated ABN indicated, "Will discharge from Physical therapy 3/23/16 due to highest level being achieved." The form was signed by the resident's daughter/POA on 3/28/16. A "Census Daily Report," dated 3/16/16, indicated PT (Physical Therapy) would discontinue on 3/16/16. The form indicated it was emailed on 3/15/2015 at 9:00 a.m.			

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	During an interview on 04/20/2016 at 9:37 a.m., the Business Office Manager (BOM) indicated she relied on the therapy departments to notify her when a resident was nearing the end of the therapy discipline. The BOM indicated notices of noncoverage by Medicare should have been provided to residents or their representatives no later than 2 days before the service ended. She indicated her Administrative Assistant processed the letters. During an interview on 04/20/2016 at 2:15 p.m., Business Office Administrative Assistant (BOAA) indicated separate "cut letters" should be sent for each therapy discipline. She indicated she mailed ABN's weekly and made a copy of the letter for herself. She indicated if a signed letter was not returned within a week, she mailed another copy. She indicated she did not have a system for tracking when a letter was received by the representative and indicated she did not call the resident's representatives until 3 attempts were made to get a letter returned via mail. An undated SNF [Skilled Nursing Facility] Notices of Non-Coverage Cheat Sheet was provided by the BOAA on 4/20/16 at 10:33 a.m. The document			

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	indicated Notice of Medicare Non-Coverage (NOMNC (CMS-10123) should be given no later than 2 days before covered services end. 3.1-4(f)(3)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop	F 0279	F=0279 SS=D Care plans for residents #8, 29, and 47 were	05/25/2016

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	comprehensive care plans for 3 of 30 residents reviewed for care plans. (Resident #8, #29, and #47). Findings include: 1. Review of Resident #8's medical record on 4/20/16 at 9:10 a.m., indicated the resident's diagnoses included, but were not limited to, dementia and osteoarthritis. A quarterly MDS (minimum data set) assessment dated 12/30/15, indicated the resident had severe cognitive deficit. The assessment indicated the resident was at risk for pressure ulcers and did not have any pressure ulcers. A quarterly MDS assessment dated 3/23/16, indicated the resident was at risk for pressure ulcers and had one pressure ulcer stage 1 or higher. During review of Resident #8's care plans, no care plan regarding pressure ulcers was found. On 4/19/16 at 3:30 p.m., the ADON (assistant director of nursing) indicated Resident #8 had developed two pressure ulcers, on the right foot, on 2/17/16. On 4/20/16 at 10:32 a.m., the ADON		created and initiated 04/20/16. All current resident's care plans will be checked for problems/needs and appropriate interventions by 5/23/16 by Director of Nursing or designee and all care plans will be initiated upon admission by the assigned nurse and completed by the MDS coordinator within the required time frame and no longer than 7 days after the MDS is completed. The care plan will be updated by each discipline as needed and as any new needs or problems arise. Each discipline will identify actual or potential problems/needs, care to be given; and goals to be accomplished. Problems/needs may be prioritized if more than one is written for a discipline. The person responsible for each procedure or activity will be identified by initials in the appropriate column. After each discipline identified problems and goals, the interdisciplinary team will develop the care plan. See exhibit (D) Care plans (RESIDENT CARE PLANNING) policy and procedure C-6-C-11 Care plans will be monitored and reviewed by the R.N. Coordinator or designee no longer than 7 days after the MDS is completed (see exhibit E). Monitoring will be completed quarterly and annually on an ongoing basis by the IDT.	

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	indicated there was not a care plan for Resident #8's right foot pressure ulcers. On 4/20/16 at 10:44 a.m., the DON (director of nursing) indicated staff would look at the resident's care plan for interventions for the resident's pressure ulcers. She indicated there was no care plan for Resident #8's right foot pressure ulcers. An undated policy, identified as current, titled, "Pressure Ulcer and Wound Management Program," indicated, "Purpose: To identify residents who are at risk for pressure ulcers...and to provide guidelines for the appropriate nursing management of wound problems...Standards:...8. The resident will be able to demonstrate...knowledge of care plan interventions...." 2. Review of Resident #29's medical record on 4/20/16 at 9:19 a.m., indicated diagnoses included, but were not limited to, cardiac septal defect and hemiplegia/hemiparesis following a CVA (cerebral vascular accident). A physician's admission order dated 12/16/15, indicated the resident was to receive 3 mg (milligrams) of Coumadin (anticoagulant) every day.			

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	A 5-day Minimum Data Set (MDS) assessment dated 12/23/15, indicated the resident received anticoagulant medication. During review of Resident #29's care plans, no care plan for anticoagulant medication use was found. On 4/20/16 at 1:17 p.m., the DON indicated if a resident was on an anticoagulant there would be a care plan for the medication. The DON indicated Resident #29 did not have an anticoagulant care plan. On 4/20/16 at 1:30 p.m., the DON provided a copy of Resident #29's anticoagulant care plan dated 4/20/16 (date initiated). 3. Review of Resident #47's medical record on 4/20/16 at 11:26 a.m., indicated the resident's diagnoses included, but were not limited to, history of DVT (deep vein thrombosis) and long term use of anticoagulants. A physician's admission order dated 3/16/16, indicated Resident #47 was to receive 4 mg of Coumadin (anticoagulant), every day. A 30-day (Medicare MDS) assessment			

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	dated 4/13/16, indicated the resident received anticoagulant medication. During review of Resident #47's care plans, no care plan for anticoagulant medication use was found. On 4/20/16 at 1:58 p.m., the DON indicated if a resident was on a anticoagulant there would be a care plan for the medication. The DON indicated she was aware no anticoagulant care plan was developed for Resident #47. On 4/20/16 at 2:00 p.m., the DON provided a copy of Resident #47's anticoagulant care plan dated 4/20/16 (date initiated). On 4/22/16 at 11:30 a.m., the DON indicated no policy on the development of care plans was available. 3.1-35(a)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a			

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	resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure pressure ulcer interventions of bilateral off loading boots were implemented for a resident identified as at risk for development of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers, which resulted in the development of an unstageable pressure ulcer to the left heel that continued to decline and a reddened area to right heel. (Resident #47). Finding includes: On 4/19/16 at 10:04 a.m., Resident #47 was observed resting in her bed. The resident was not wearing off loading boots on either foot. The resident's heels were lying on top of the mattress. On 4/19/16 at 10:48 a.m., Resident #47 was observed sleeping in her bed. The resident was not wearing off loading boots on either foot. The off loading boot for her left foot was observed to be lying in the window sill.	F 0314	F 314 SS=G CNA staff were instructed to follow the interventions recorded on the CNA assignment sheets. In addition an in-service will be held for nursing staff on 5/23/16 on pressure ulcer development, interventions, and prevention. Interventions will be placed on treatment administrationrecord and checked every shift by nurse on duty. Nurse will initial that it hasbeen checked. Wound nurse or designee will check charts weekly duringmonitoring of resident progress. The resident's physician will be notified weekly and as needed of the progress or lack of progress of the resident's pressure ulcer by the facility wound nurse and/or designee and the notification will be documented in the resident's chart weekly on an ongoing basis by the wound nurse or designee (see exhibit F).	05/25/2016

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	On 4/19/16 at 2:07 p.m., Resident #47 was observed to have an unstageable pressure ulcer to left heel. ADON described the wound as 75% eschar, 15% mushy necrotic (dead tissue) soft tissue, and 10% granulation tissue with peri wound irregular. On 4/20/16 at 2:14 p.m., Resident #47 was observed awake in her bed with the hard off loading boot was in the window sill and not on the resident's left foot. Soft off loading boot was not observed to be on the resident's right foot. On 4/21/16 at 10:02 a.m., Resident #47 was observed sleeping in her bed. Hard off loading boot was lying in her wheelchair and not on her left foot. Soft off loading boot was not observed to be on the resident's right foot. On 4/21/16 at 11:03 a.m., Resident #47 was observed sleeping in her bed. Hard off loading boot was lying in her wheelchair and not on her left foot. Soft off loading boot was not observed to be on the resident's right foot. On 4/22/15 at 2:56 p.m., Resident #47 was observed resting in her bed. Hard off loading boot was lying in her wheelchair and not on her left foot. Soft off loading			

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	boot was not observed on the resident's right foot. During an interview on 4/19/16 at 9:38 a.m., ADON (assistant director of nursing) indicated Resident #47 had an unstageable pressure ulcer to the left heel and should be wearing a hard off loading boot to the left heel at all times. She further indicated the resident should be wearing a soft off loading boot to the right heel, while in bed, as a preventive measure. She further indicated a new wound treatment order was obtained on 4/18/16. During an interview on 4/19/16 at 2:07 p.m., CNA (certified nurses aid) #4 indicated Resident #47 should be wearing a soft boot to the right heel while she is in bed at all times. During an interview on 4/19/16 at 3:28 p.m., ADON indicated the CNA assignment sheet will contain the information needed for staff on interventions put into place for a resident with pressure ulcers. Review of CNA assignment sheet on 4/19/16 at 3:50 p.m., lacked documented interventions for placement of off loading bilateral boots.			

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	A copy of an updated and revised CNA assignment sheet was provided by the DON on 4/20/16 at 9:00 a.m., and included the following interventions: "off loading boot to left foot at all times and soft off loading boot to right foot while in bed." Resident #47's record was reviewed on 4/20/16 at 11:21 a.m. Resident #47 had diagnoses which included, but were not limited to, Dementia, left hip fracture, and osteoporosis. Review of pressure ulcer risk assessment dated 3/18/16 indicated, Resident # 47 had a score of 20, which indicated resident is at high risk for developing pressure ulcers. A Minimum Data Set (MDS) assessment, dated 3/23/16, indicated Resident #47 required assistance of two persons for mobility and identified the resident was at risk for developing pressure ulcers. A plan of care dated 12/3/14 and revised on 3/21/16, indicated the resident has a potential for pressure ulcer development related to being in bed most of the day. The following intervention included but was not limited to, "... off loading boots bilateral while in bed....." Review of weekly skin sheets indicated			

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	the following measurements: A. Dated 3/21/16 Stage 2 to left heel measuring 6.3 cm(centimeter) x 5 cm, suspected deep tissue injury with intact fluid filled blister. B. Dated 3/24/16 Stage 2 to left heel measuring 5.5 cm x 10 cm, intact blood filled blister. C. Dated 2/28/16 Stage 2 to left heel measuring 9.5 cm x 10 cm, non intact small opening. D. Dated 3/30/16 Stage 2 to left heel measuring 9.5 cm x 11 cm, non intact purple open area. E. Dated 4/3/16 Stage 2 to left heel measuring 3 cm x 4.8 cm, non intact skin flap peri wound. F. Dated 4/12/16 Stage 2 to left heel measuring 8.5 cm x 9.5 cm, less than 0.2 cm depth, full thickness 100% beefy wound bed. G. Dated 4/18/16 Unstageable to left heel measuring 5.9 cm x 5 cm, 25% gray moist necrotic and 75% dry black eschar. Physician orders reviewed and			

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	documentation lacked notification to the physician of increase in size and worsening of left heel wound. According to weekly skin sheets the wound increased in size and worsened on 4/12/16. An undated facility policy titled, "Pressure Ulcer and Wound Management Program," identified as current by DON on 4/21/16 at 1:35 p.m., included but was not limited to "... 8. Physicians will be kept informed of progress or lack of progress of wound treatment measure and healing...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0323 SS=J Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to ensure portable oxygen tanks were stored at a safe distance from the heat of hair dryers, salon equipment was inspected routinely for good operating condition, and staff were trained what to do in case of a fire, including how to use the fire extinguisher	F 0323	F 0323 SS = J Part A - Beauty Shop We are requesting an IDR solely for the purpose providing evidence to support reducing the IJ to a lower classification. We believe the imposed penalty far exceeds the infraction. We would simply like to have the opportunity to explain. On 04/21/16, the day of the finding, the following Plan	05/25/2016

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	for 3 of 3 residents who received salon services while 2 portable oxygen tanks were stored next to the hair dryer's heat source and motor (Residents #23, #9, and #35). B. In addition to the residents in the Immediate Jeopardy, the facility failed to ensure a cognitively impaired resident was supervised at all times during medical appointments resulting in harm or potential harm that is not Immediate Jeopardy for 1 of 1 resident reviewed for supervision during medical appointments (Resident #47). The Immediate Jeopardy was identified on 04/21/2016 and began on 04/21/2016 when 2 of 3 residents in the facility's hair salon were observed seated in wheelchairs with portable oxygen stored on the back of the wheelchair and within 6 inches of the heat source and motor of the hooded hair dryers. The Administrator was notified of the Immediate Jeopardy on 04/21/2016 at 4:15 p.m. Findings include: A1. During an observation on 04/21/2016 at 11:05 a.m., Resident #23 was seated in a wheelchair under a hooded hair dryer, while it was in operation, in the facility's hair salon. The		of Correction was instituted and submitted to the appropriate ISDH personnel via e-mail that evening: The Salon Safety Policy/Procedure was created (Exhibit N Revised) ·Signature attesting review by Salon Cosmetologist was immediately obtained (Exhibit W) ·All employees on duty that evening (04/21/16) reviewed the policy and signed acknowledgement of such. (Exhibit Y) ·Distribution and sign-off by employees was re-instituted early the following morning (04/22/16) and thereafter for staff not present that evening. Each employee was being given a copy of the policy and copies were posted at nurses' stations. ·Safety Check was performed the evening of 04/21/16 by the maintenance staff (Exhibit X) ·This Safety Check was performed again in one week and will now be done monthly thereafter. (Exhibit O) Upon reviewing the Official report and working on the Plan of Correction,effective 05/27/2016, there will be a designated time for all residents who areunable to be without supplemental oxygen to utilize the salon. During thedesignated time no hairdryers will be in use. Residents receiving salonservices during the designated times will air dry. A new sign will be placed onthe Salon Door stating "No oxygen	

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	resident had oxygen delivered via nasal cannula with a portable oxygen tank stored on the back of her wheelchair. A rolling, hooded, electric hairdryer was placed directly behind the wheelchair with the heat source and motor 6 inches from the oxygen tank. Eight cans of hair spray were stored on the stylist's rolling cart and had labels indicating contents were flammable. The rolling cart was 3 feet from the resident. Fourteen additional hair products with labels indicating items were flammable were stored in a stationary cabinet in the salon. A2. During an observation on 04/21/2016 at 11:05 a.m., Resident #9 was seated in a wheelchair under a hooded hair dryer, while it was in operation, in the facility's hair salon. The resident had oxygen delivered via nasal cannula with a portable oxygen tank stored on the back of her wheelchair. A rolling, hooded, hairdryer was placed directly behind the wheelchair with the heat source and motor 6 inches from the oxygen tank. A3. During an observation on 04/21/2016 at 11:05 a.m., Resident #35 was observed seated in the salon chair while the beautician was spraying her hair with aerosol hairspray identified as flammable. The resident was less than 5		allowed in Salon except during designatedtimes. During designated no hairdryers are in use" (exhibit R Revised). Also the DON or designee will train the salon staff on signs of hypoxia and what to do if signs are present. The New Policy will be distributed by Activity Director to nursing staff and to the Salon Operator on 05/13/16 and we will continue to train new staff and thereafter training will be offered in our annual in-services Monitoring will be ongoing by the Activity Director and Maintenance Dept F323 (B) Facility respectfully requests an Informal Dispute Resolution (IDR) for the alleged deficiency of F323 (Part B) for resident#47. Resident was transferred to the Endocrinologist physician office with facility personnel who stayed in attendance during the visit of 4/18/16. Facility staff sent medical information (including transfer form, medication administration information, diagnoses, lab work result information and MD progress notes from the primary physician). Per facility information (received 4/19/16 for the appointment on 4/18/16) from the Endocrinologist regarding neurological assessment, physician documented in progress note, **"There is no muscular weakness, Reflexes: normal. Gait: normal. Orientation: The patient is alert and oriented to person, place**	

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	feet from 2 other residents who were seated under hood hair dryers with portable oxygen tanks stored in close proximity of the heat source and motor. At 11:10 a.m. the Director of Nursing (DON) and Assistant Director of Nursing (ADON) turned off the hair dryers and moved Residents #23 and #9, utilizing oxygen, into the hallway outside the salon. During an interview at that time, Beautician #1 indicated she was not aware of any precautions with oxygen tanks near the hair dryers. During an interview on 04/21/2016 at 11:33 a.m., the DON and ADON indicated the resident's portable, liquid oxygen tanks were approximately 6 to 8 inches from the hair dryer when stored on the back of the wheelchairs and the rolling dryers were placed directly behind the chairs. During an interview on 04/21/2016 at 11:53 a.m., the Administrator indicated he had not thought about residents wearing oxygen into the beauty shop and had not mentioned it to the beautician. During an interview on 04/21/2016 at 2:08 p.m., Beautician #1 indicated she had not been provided training regarding safe use of oxygen in the salon. She was		**and time. The responses to questions are appropriate"**(Exhibit # 323 A). Due to the information presented above, the facility respectfully requests deletion of F323 for resident #47 due to physician's ability to treat resident #47 appropriately. Activity Director has updated the Transportation Envelope to include the reason for consultation on first sheet of paperwork (exhibit S) and made a form (exhibit T) for that information to be filled out by nursing and included in the packet for resident. This will help with reason for visit if no family is able to attend. 1.Activity Director has also updated the Transportation request form (exhibit U) that nursing fills out to include BIM score. Any resident below a BIM score of 9 will be supervised during Dr.appointment if there is no family present. 2.Activity Director has updated the Transportation/Scheduler Policy (exhibit V) to reflect the new updates to policy. Transportation and Nursing will be trained by Activity Director on 5/13/16 and will be reiterated at Nursing in-Service on 5/23/16 to be completed by 5/25/16 and then at annual in services thereafter. Activity Director will monitor all incoming transportation requests weekly with Driver/Scheduler to ensure that all new policies are being	

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	not aware that if it was a safe option, the oxygen should be removed while the resident was under the dryer. She was not aware of an appropriate distance to store the oxygen tank when the resident was under the hair dryer. The beautician indicated all of the salon equipment belonged to the facility. She had not received training regarding heat temperatures for the hair dryers but tried to ensure temperatures were at a level that was comfortable for the resident. The beautician indicated residents from the facility's assisted living program had been left unattended in the salon with oxygen in place while under the hair dryer for a few minutes while she went to check the activity calendar or menu. No residents from the health center residents had been left unattended. The beautician had not been trained what to do if there was a fire but knew how to use a fire extinguisher. The facility had not trained her to use their extinguisher. . During an interview with the Administrator and the Maintenance Director on 04/21/2016 at 2:30 p.m., the Maintenance Director indicated there was no system for routine inspection of salon equipment to ensure good operating condition and safe heat temperatures of hair dryers. The Administrator indicated he did not have a policy for the salon and		followed.	

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	had not provided training to salon staff in regard to safe use of oxygen. An undated NFPA (National Fire Prevention Association) document referenced in the LTC (Long Term Care) Newsletter # 09-36) indicated, "...Oxygen should be stored at least 8 feet (2.4 meters) away from...heaters, heat-producing devices...hair dryers, and most other electrical appliances. Oxygen should be stored in well-ventilated areas. Storage in closets and behind drapes is not considered to be in a well ventilated area and should be avoided....." A facility policy related to oxygen use in the hair salon was requested on 04/22/16 at 11:39 a.m. The DON indicated there was not a policy at 12:15 p.m. B. During an interview on 4/20/16 at 9:52 a.m., LPN #2 indicated a CNA (certified nurses assistant) will accompany a resident to a physician appointment when the resident requires physical assistant or are cognitively impaired. During an interview on 4/21/16 at 9:39 a.m., the DON indicated the driver stays with the resident at the doctor's appointment but will wait in the lobby while the resident is in the exam room. During an interview on 4/21/16 at 12:17 p.m., the Activity Director indicated the			

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	transportation driver is not trained to take residents to the restroom while out to doctor's appointments. She further indicated the driver does not go into the exam room with the residents. Resident #47's record was reviewed on 4/20/16 at 11:21 a.m. Diagnoses included, but were not limited to, left hip fracture and dementia. A Minimum Data Set (MDS) assessment, dated 3/23/16, indicated Resident #47 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. A MDS assessment, dated 4/13/16, indicated Resident #47 required two persons physical assist with toileting and transfers. Resident #47 uses a wheelchair as a mobility device. A plan of care, initiated on 7/3/14, indicated Resident #47 has a communication problem related to hearing deficit. A plan of care, initiated on 8/11/14, indicated Resident #47 has bladder incontinence related to dementia. A Plan of Care, initiated on 6/4/15, indicated Resident #47 has an ADL			

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	(activities of daily living) self-care performance deficit related to impaired balance. A Plan of Care, initiated on 2/2/16, indicated Resident #47 has had an increase in confusion due to the dementia progress. A plan of care, initiated on 2/19/16, indicated Resident #47 is a high risk for falls related to general weakness. A progress note dated 4/18/16, indicated Resident #47 was seen by an Endocrinologist outside of the facility on the above date. The physician wrote the following statement, "Patient is nonverbal to prior notes has DEMENTIA. Not accompanied by any family member??? Is here only with driver." A typed progress note dated 4/18/16, indicated Resident #47 was seen by an Endocrinologist for Thyroid dysfunction. The progress noted indicated Resident # 47 was with no family member and is non verbal. An undated policy titled, "A Transportation/Scheduler Policy" and identified as current by the Activity Director on 4/21/16 at 12:17 p.m. The			

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	policy indicated, "... If an additional CNA is needed get with nursing scheduling or supervisor to arrange...." The Immediate Jeopardy that began on 04/21/16 was removed on 04/22/16 when the facility provided training to the beautician and facility staff regarding safe use of oxygen in the salon and the Maintenance Director inspected salon equipment to ensure good operating condition and safe heat temperatures of the hair dryers. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued training and monitoring for safe use of oxygen in the salon and how to respond if there was a fire. 3.1-45(a)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate			

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	monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure GDR's (gradual dose reductions) for a nebulizer treatment, two anxiolytics, and an antipsychotic medication, were reviewed and acted upon by the attending medical doctor when recommended by a pharmacist for 1 of 5 residents reviewed for unnecessary medications (Resident #28). Finding includes: The record for Resident #28 was reviewed on 4/19/16 at 11:30 a.m. Diagnosis included, but was not limited to dementia. A physician's recapitulation order, dated March 2016, indicated Albuterol Sulfate	F 0329	F0329 SS=D The Doctor has addressed the recommendations from the pharmacy consultant and no resident was harmed by the failure to answer the recommendations in a timely manner. The consultant pharmacist will conduct MRRs (Medication Regimen Review) if required under a Pharmacy Consultant Agreement (see Policy 9.1 Medication Regimen Review G) The Director of Nursing will receive a copy of the Pharmacy consultant recommendations monthly from the consultant. Consultant report will be reviewed by IDT in weekly risk meeting. IDTwill monitor adverse consequences of medication, lowest possible dose, orcontinued need for the medication weekly at risk meeting and will notifyphysician if change	05/25/2016

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	2.5 mg (milligrams)/3 ml (milliliters) solution inhale 3 ml orally every 6 hours as needed for SOB (shortness of breath) was ordered on 12/2/15; Lorazepam 0.5 mg tablet give 1 tablet by mouth every 8 hours as needed for anxiety was ordered 9/29/15; Buspirone HCL 5 mg tablet give 1 tablet by mouth 2 times a day for dementia with behavioral disturbances ordered 1/14/16; and Quetiapine 25 mg tablet give 1 tablet by mouth at bedtime for dementia with behavioral disturbances ordered 1/14/16. A pharmacy consultant report, dated 10/13/15, indicated, "...[Resident's name] has received routine Albuterol Med nebs QID (4 times daily) for SOB (shortness of breath)/Pneumonia since 9/16/15. Recommendation: Please re-evaluate the continued need for routine Albuterol med nebs, perhaps discontinuing it use, if the individual's condition is stable. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences. IF CHRONIC USE IS REQUIRED, PLEASE		is suggested. The Director of Nursing or designee will notify the physician of the MRRs monthly. The physician will be notified of the Pharmacy consultant recommendations within 48 hours after receiving the report. The MRR's will be followed up on within 72 hours of notification of the physician by the DON or designee (see exhibit H). If no response has been received after the 72 hours, the facility Medical Director will be contacted by DON or designee. Monitoring will be ongoing by the Director of Nursing or designee	

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	DOCUMENT A SUPPORTING DIAGNOSIS...." A pharmacy consultant report, dated 10/13/15, indicated, "...[Resident's name] has following PRN (as needed) medication orders do not include an indication for use: 1) Lorazepam. Recommendation: Please send a clarification order to the pharmacy which includes an indication for use in the directions of the order. Rationale for Recommendation: Long-term care regulations require a specific dose, frequency and indication for all PRN orders to avoid confusion and potential for inappropriate use. Ranges are not allowed with these orders, since the order could be interpreted differently by each caregiver...." A pharmacy consultant report, dated 1/15/16, indicated, "...[Resident's name] has received a routine anxiolytic, Buspar. Federal nursing regulations require that anxiolytic agents be used routinely only when evidence exists that other possible reasons for distress have been considered, use results in maintenance or improvement in the resident's well-being and one or more of the following conditions exists: 1. Generalized anxiety disorder 2. Panic disorder 3. Sleep disorders 4. Symptomatic anxiety that			

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	occurs in individuals with another diagnosed psychiatric condition 5. Acute alcohol or benzodiazepine withdrawal 6. Significant anxiety in response to a situational trigger 7. Delirium, dementia or other cognitive disorders with associated behaviors that are a) quantitatively and objectively documented; b) persistent; c) are not due to preventable or correctable reasons; and d) Constitute clinically significant distress to the resident or represent danger to the resident or others 8. A long-acting benzodiazepine is being used to withdraw a resident from a short-acting benzodiazepine 9. Neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia, restless leg syndrome or seizure disorders). 10. Symptom relief in end of life situations. Recommendation: Please indicate the appropriate diagnosis requiring treatment with anxiolytic therapy from the list above, or consider gradual anxiolytic tapering and/or discontinuation if used to manage behavior, stabilize mood, or treat a psychiatric disorder." A pharmacy consultant report, dated 3/22/16, indicated, "...[Resident's name] receives Quetiapine 25 mg QHS (every bedtime) for behavioral or psychological symptoms of dementia (BPSD) since			

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	1/14/16 (this was a dose increase due to a failed dose reduction attempt). CMS (Centers for Medicare and Medicaid Services) regulations require at least a quarterly review to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose. Resident has failed one trial dose reduction attempt. Recommendation: For the second at gradual dose reduction (GDR) in the facility, please consider decreasing to Quetiapine 12.5 mg QHS, if appropriate for this resident, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms." The "Behavior/Intervention Monthly Flow Record" indicated Resident #28 did have behaviors of hitting, cursing, and yelling out at staff during the data collection period of March 2016. No documentation indicated the recommended GDR had been received and acted upon by an attending medical doctor. During an interview on 4/21/16 at 3:12 p.m., the DON (Director of Nursing) indicated she was unable to obtain a physician's response or an explanation regarding the rejection of the pharmacist's recommendations to attempt the GDR's. A facility policy and procedure to process			

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	pharmacy recommendations for GDR was requested and none provided. 3.1-48(b)(2)			
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure meals were served under sanitary conditions in the ground floor dining room for 28 of 28 residents. Findings include: During a dining observation on 4/17/16 at 12:19 p.m., CNA #11 was observed to wash her hands for < (less than) 10 seconds and then proceeded to serve three residents in the dining room plates of food, while she chewed bubble gum. The employee carried the plates with her thumb in contact with the interior surface area of the plates where food was placed.	F 0371	F 0371 SS=D CNA # 11 & 12 were verbally instructed the proper way to serve meals to residents. No residents were harmed by the failure to properly serve the plates. All Nursing staff will be in-serviced on 5/23/16 on the proper way to serve meals and proper hand-hygiene procedure (see exhibit I). Dining services director and/or assistant director will monitor servingof 3 meals weekly for 6 months. Each meal time will be observed once per week(breakfast, lunch, supper). At conclusion of 6 months serving of dining roomswill be observed by dining services director and/or assistant director on anongoing basis. The Registered Dietician or designee will monitor and observeserving of the meals bi-weekly on an ongoing basis (see exhibit J).	05/25/2016

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	On 4/17/16 at 12:20 p.m., CNA #12 was observed in the dining room to serve 2 plates of food to residents. The employee carried the plates with her bandaged thumb on the interior surfaces of the residents' plates, without any hand sanitation. On 4/22/16 at 10:59 a.m., the DON (Director of Nursing) indicated staff serving food to residents should wash their hands for at least 15 seconds prior to serving the food, staffs' hands were not to be in contact with the interior surfaces of the plated food, staff should wear gloves, if they have a bandage on their hand, and staff were not to chew gum while serving food to the residents in the dining room. On 4/22/16 at 2:45 p.m., the Director of Dietary Services indicated staff were to wash their hands for at least 15 seconds before they served plated food to a resident, staff were not to touch the food contact surfaces of a plate, when they served plated food to residents, and staff were not to chew bubble gum while serving food to residents in the dining room. The DON provided a copy of the undated policy and procedure documentation on 4/22/16 at 10:55 a.m., titled " Hand Hygiene Procedure. " The policy			

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	indicated "...Purpose: To remove dirt, organic material and transient microorganisms from the hands ...Procedure ...4. Apply hand washing agent. Lather all surfaces of hands and wrists and between fingers. 5. Vigorously rub hands together to create friction for at least 15 seconds...." Documentation, identified as a current facility policy titled, "Retail Food Establishment Sanitation Requirements," provided by Director of Dietary Services on 4/22/16 at 3:06 p.m., indicated, "...When to wash hands...Food employees shall clean their hands...before touching food or food-contact surfaces...an employee shall chew gum, eat and drink food, or use any form of tobacco only in designated areas where the contamination of: exposed food...." Handwashing section 128 page 28 hand cleaning procedure...for at least 20 seconds. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the			

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	services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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, interview, and record review, the facility failed to ensure 1 vial of Aplisol solution were not expired for 1 of 2 observed refrigerators utilized for medication storage. Finding includes:	F 0431	F 0431 SS=D The expired Aplisol was removed promptly from the refrigerator on 04/22/16 Nursing staff will be in-serviced on 5/23/16 on the expiration date of Aplisol and or Tubersol. A signature column has been added to the daily temperature log in which the night shift nurse will	05/25/2016

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	During an observation on 4/22/16 at 11:05 a.m., a vial of Aplisol solution was in the first floor medication refrigerator with an open date of 2/24/16. During an interview on 4/22/16 at 11:05 a.m., LPN #5 was unaware of the expiration date of a vial of Aplisol once it had been opened . During an interview on 4/22/16 at 11:40 a.m., DON (director of nursing) indicated a vial of Aplisol is good for 30 days from the open date. On 4/22/16 at 1:45 p.m., A pharmalogical insert undated was received by DON and was identified as the current policy the facility uses for Aplisol. The insert included but was not limited to, ... "Storage"..."Vials in use for more than 30 days should be discarded".... 3.1-25(o)		check the refrigerator nightly on an ongoing basis for expired medication (see exhibit K). A representative from the pharmacy will continue to check the medication in the medication carts monthly as contracted by the facility on an ongoing basis for expired meds. The representative for the pharmacy will leave a copy of the report for the DON and Administrator for review. Monitoring will be ongoing by the Director of Nursing or Designee	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an			

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	Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the 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, interview, and record review, the facility failed to ensure proper infection control procedures and hand hygiene were maintained for a resident observed for wound care	F 0441	F 0441 SS=D ADON, LPN#3 and LPN#2 were verbally in-serviced on the proper infection control procedure during wound care and hand hygiene procedures. All Nursing staff will be in-serviced	05/25/2016

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	(Resident #47) and for a resident observed for medication administration (Resident #31). Findings include: 1. During an observation of wound care on 4/19/16 at 2:07 p.m., ADON (assistant director of nursing) and LPN #3 did not wash their hands prior to entering Resident's #47 room. After staff entered the room they donned gloves. ADON adjusted the resident's bed height using controls on the right side rail of the bed. LPN #3 held Resident's left heel up off the bed as the ADON began to cut the kerlix gauze wrap. ADON then proceeded to open a 4 x 4 gauze pack with the same gloves on. ADON and LPN #3 then adjusted a blanket on the bed by pushing it towards the foot board of the bed. LPN #3 held resident's left heel as the ADON removed the old dressing. ADON removed gloves and donned new pair of gloves. LPN #3 continued to hold resident's left heel off the bed as the ADON used a wound cleanser to clean the wound per physician order. ADON then applied ointment to wound area and a hydrogel gauze. She then wrapped the heel with kerlix gauze and applied tape to secure. ADON proceeded to remove her gloves and obtained a black marker to date and		on 5/23/16 on proper infection control procedure (see exhibit I) and hand hygiene (see exhibit I) The DON or designee will monitor proper hand hygiene during a dressing change and while giving an injection on a weekly, ongoing basis (see exhibit L Revised and M Revised).	

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	initial the dressing change. A hard off loading boot was placed on resident's #47 left heel and placed a soft off loading boot on right heel. ADON and LPN #3 placed blankets back on top of the resident as she rested in bed. LPN #3 went into resident's restroom and washed her hands for 10 seconds. ADON also went into resident's restroom to wash her hands, she washed them for 13 seconds. During an interview on 4/21/16 at 9:59 a.m., DON indicated staff should wash their hands before and after donning gloves. A facility policy, titled "Standard Precautions Infection Control", dated 2014, included but was not limited to, "...e. Perform hand hygiene: i... Before having direct contact with patients. vi... After removing gloves...." 2. On 4/21/16 at 7:59 a.m., LPN (Licensed Practical Nurse) #2 was observed to enter Resident #31's room, don gloves, and give Resident #31 a medication via an injection. LPN #2 then proceeded to leave the room, while she still wore the gloves and carried the used medication syringe to the medication cart in the hallway, where she disposed of the used syringe and soiled gloves. LPN #2 was not observed to perform hand			

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	sanitation. On 4/21/16 at 8:28 a.m., LPN #2 indicated she should have washed her hands before and after giving an injection and should have disposed of the soiled gloves and used syringe in the resident's room, not wear the gloves to the medication cart and then dispose of the soiled gloves and used syringe in the hallway. On 4/21/16 at 8:44 a.m., the DON (Director of Nursing) indicated staff are to wash their hands before and after removing gloves when they give an injection to a resident and dispose any used items into the trash can in the resident's room, not take the soiled items out of the room to the medication cart. A policy titled, "Standard Precautions Infection Control," dated 2014 and identified as current by the DON on 4/22/16 at 10:55 a.m., indicated, "...Perform hand hygiene...Before having direct contact with patients...After contact with a patient's intact skin...After removing gloves...." The DON provided a copy of the undated policy and procedure documentation on 4/22/16 at 10:55 a.m., titled " Hand Hygiene Procedure. " The policy			

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R 0000	indicated "...Purpose: To remove dirt, organic material and transient microorganisms from the hands ...Procedure ...4. Apply hand washing agent. Lather all surfaces of hands and wrists and between fingers. 5. Vigorously rub hands together to create friction for at least 15 seconds...." Documentation, titled "HOW TO HANDWASH," from the World Health Organization, dated May 2009, indicated, "...0 Wet hands with water; 1 Apply enough soap to cover all hand surfaces; 2 Rub hands palm to palm; 3 Right palm over left dorsum with interlaced fingers and vice versa; 4 Palm to palm with fingers interlaced; 5 Backs of fingers to opposing palms with fingers interlocked; 6 Rotational rubbing of left thumb clasped in right palm and vice versa; 7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;...Remember: Steps 2-7 - 20 seconds...." 3.1-18(a) 3.1-18(l)			

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Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 54 Sample: 05 Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey. Q.R. completed by 14466 on May 02, 2016.	R 0000		