STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	01/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

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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 IN00215472. Complaint IN00215472 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 & F 282. Survey dates: January 23, 24, 25, 26, 27, and 30, 2017 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census bed type: SNF/NF: 81 Total: 81 Census payor type: Medicare: 12 Medicaid: 59 Other: 10 Total: 81 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on	F 0000	Please find the enclosed plan of correction for the survey ending January 30, 2017. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	

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

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	February 1, 2017.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.			

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	(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interviews, the facility failed to ensure physician and/or family/responsible parties were notified when a resident's blood sugars exceeded set parameters; laboratory blood draws were not obtained as ordered; a Wanderguard bracelet was not discontinued; new orders were clarified for an anti-depressant; family declined psychiatric services; psychiatric notification of refusal of treatment; and notification of medication error. This deficient practice affected 3 of 6 residents reviewed for Physician Notification. (Resident E, F, & G) Findings include: 1. Review of the clinical record for Resident E, on 1/24/17 at 9:00 a.m., indicated the resident had diagnoses	F 0157	1.Resident E, F, and G's physician and resident representatives were notified regarding out of range blood glucose readings, omitted laboratory orders, wander guard bracelets to be discontinued, clarified psych medications, psych services, refusal of treatments, and medication errors as applicable. 2.All other residents have the potential to be affected by the alleged deficient practice. The DNS or designee will complete house wide audit of all residents with orders for blood glucose checks, labs, wander guard bracelets, psych medications, psych services and will notify physician and resident representatives of all findings including: refusal of treatments and medication errors as well as update resident care plan/profile by 2-10-17.	02/10/2017

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	which included, but were not limited to: cerebral infarction and vascular dementia with behavioral disturbance. On 11/10/16, a progress note was written by the nurse for "New order received for psych (psychiatric) referral." Review of Physician orders between 8/16/16 and 1/25/17 failed to locate an actual written order. On 11/18/16, a progress note written by the SW (Social Worker) indicated she had talked with resident's (family member) about his behaviors and having the resident seen by the psychiatrist. The (Family member) declined for him to be seen by the psychiatrist at this time. Documentation was lacking in which the physician had been notified of the family's refusal for psychiatric services. On 12/20/16, the Psychiatrist saw the resident and wrote new orders to change the resident's medications. On 1/24/17, the Psychiatrist visited the resident and no documentation was found where the psychiatric group had been notified of the family's refusal for the resident to be seen. In an interview with LPN (License Practical Nurse) 2, on 1/25/17 at 1:25 p.m., she replied "I'm not sure if it is a		3.CEC or designee will in-service licensed nursing staff on physician/resident representative notification and change in condition by 2-10-17. 4.DNS or designee will monitor weekly using Nursing Monitoring Tool times 4 weeks, monthly times 4 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 90% or above.	

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	standing order we always get at admission for the resident to see psych [psychiatric] services or if it is obtained only as needed". During an interview with LPN 2, on 1/25/17 at 1:45 p.m., she indicated "Everyone has a standing order at admission to see psych [psychiatric] services and then either the resident or the POA [Power of Attorney] is contacted and consent is signed." On 1/26/16 at 1:25 p.m., LPN 3 indicated, when the facility received an order for the resident to see the psychiatric services, the MCF (Memory Care Facilitator) or SW will notify the psychiatric group and notify family for consent. If the family declines services, then usually nursing will notify the physician to discontinue the order. On 1/30/17 at 10:20 a.m., the SW indicated she did not call, and it was up to the Memory Care Facilitator to call the family for consent. During an interview, on 1/30/17 at 10:37 a.m., the Director Of Nursing (DON) presented a "Resident Consent for Psychiatric Services", dated 12/19/16, in which the Social Worker indicated she obtained verbal consent from the family.			

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	The DON stated the Social Worker told her it was in her planner and she had just found it. 2. Review of the clinical record for Resident F, on 1/25/17 at 11:15 a.m., indicated the resident had diagnoses which included, but were not limited to: insulin dependent diabetes mellitus, schizoaffective, dementia without behavior disturbance, and anxiety disorder. Review of the physician orders for January 2017 indicated the resident had a standing order dated 11/16/16 for Accu checks (to check amount of sugar in the blood) QID (4 times a day) and give Novolog (insulin) per sliding scale: " blood sugar of 401 to 450 give 15 u [units] ... >[greater] than 450 give 18 u and call NP/PA [Nurse Practitioner/Physician Assistant]". Review of the Diabetic Administration History, for 11/15/16 through 1/24/17, indicated the resident's BS (blood sugar) was greater than 450 and no MD (Medical Doctor) notification was made for the following dates: - 11/17 at 12:00 noon / BS of 546 - 11/17 at 4:00 p.m. / BS of 461 - 11/20 at 12:00 noon / BS of 470 - 11/20 at 4:00 p.m. / BS of 490			

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	- 11/23 at 12:00 noon / BS of 467 - 11/30 at 9:00 p.m. / BS of 496 - 12/03 at 9:00 p.m. / BS of 480 - 01/18 at 12:00 noon / BS of 461 Review of the Diabetic Administration History, for 11/17/16 at 6:00 a.m., indicated the resident was given 18 units of Novolog instead of the scheduled 15 units for a BS of 446. No documentation of the NP/PA being notified in the resident's clinical record. During an interview, on 1/26/17 at 1:20 p.m., LPN 3 indicated "when blood sugar readings are above or below the set parameters, we are supposed to call the MD for new orders." On 11/22/16, the Psychiatrist completed an initial evaluation and ordered a VPA (Valproic Acid) level be drawn. If the VPA level was low, the Psychiatrist was going to increase the resident's medication (Depakote - a medication used for psychosis). Review of the Laboratory tests between 11/22/16 and 1/24/17 indicated no laboratory results could be found for a VPA level. On 1/25/17, a nursing note was written in which a VPA level was drawn on this day. Documentation was lacking of the psychiatrist having been notified of the			

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	laboratory value not being drawn per order on 11/22/16. On 12/12/16, the nursing progress note indicated a new order was received to "D/C [discontinue] Wanderguard" (a bracelet that alerts staff if resident near an exit door). The January 2017 monthly physician orders also noted the Wanderguard was discontinued effective 12/12/16. Observation of Resident F, on 1/23/17 at 10:45 a.m. and 1/25/17 at 5:50 p.m., indicated the resident's Wanderguard remained on her right ankle. In an interview on 1/26/17 at 1:20 p.m., LPN 3 stated "I don't know why the resident still had her Wanderguard bracelet on..." During an interview with the Director of Nursing on 1/30/17 at 10:30 a.m., she indicated the Wanderguard was never really supposed to have been discontinued and did not know why the nurse wrote the order to discontinue the Wanderguard. 3. Review of the clinical record for Resident G, on 1/27/17 at 9:30 a.m., indicated the resident had diagnoses which included, but were not limited to: psychosis not due to a substance or			

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	known physiological condition, schizophrenia, recurrent depressive disorders and vascular dementia with behavioral disturbance. The January 2017 Monthly Physician Orders indicated the resident had the following orders: - 9/16/16 Lantus 25 u (Units) SQ (subcutaneous) HS (at night) - 9/18/16 Novolog SS (sliding scale) Insulin QID (4 times a day) - 9/28/16 Zoloft 50 mg (milligrams) - 1 tablet every AM (morning) - 9/28/16 Zyprexz 2.5 mg - 1 tablet every AM - 9/28/16 Zyprexa 5 mg - 1 tablet every HS On 11/18/16, the pharmacy made a recommendation: "Resident has diabetes, but a recent A1c [glycated hemoglobin, amount of sugar in the blood] is not available in the resident's record. Please consider monitoring A1c on the next convenient lab day and then Q [every] 3 months if therapy has changed or goals are not being met, or every 6 months if meeting treatment goals..." On 12/12/16, the Nurse Practitioner accepted the recommendation and implemented the order for an A1c at the			

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	next laboratory draw day and then every three months. This order was noted by nursing and was written as "New order received to obtain A1c, ...valporic acid levels every 3 months." The order failed to include an A1c level to be drawn at the next laboratory draw day. On 12/16/16, the laboratory staff was in the facility to draw the residents blood work, but the A1c was not drawn. During an interview, on 1/30/17 at 10:00 a.m., the DON indicated she did not know why the nurse failed to include the A1c in the order to be drawn at the next lab day. On 1/24/17, the psychiatrist wrote new orders for the resident. The new orders were written for: "Increase Zyprexa (for psychosis) to 3 mg Q am and 5 mg Q HS; Zoloft 12.5 mg Q am x 7 days, then increase Zoloft to 25 mg Q am for depression." Review of the current MD orders as of 1/26/17 failed to note the changes having been made or the Zoloft order clarified as resident was currently on Zoloft 50 mg Q AM. On 1/26/17 at 3:10 p.m., LPN 4 stated when the physician agrees with the pharmacy recommendations, the physician will write an order. If the			

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	physician does not write the order or calls the order to the facility, staff will write out the orders for the physician to sign. An EVENT was opened to show a new order was received. Review of the resident's clinical record failed to document an EVENT being opened or the order written. On 1/27/17 at 10:23 a.m., the DON indicated she was unable to give a reason for the orders not being implemented or clarified. On 1/30/17 at 10:47 a.m., the DON indicated "Nursing noticed this psychiatric order yesterday and were talking about how the Zyprexa does not come in 3 mg, but nothing was done about it". On 1/27/17 at 10:05 a.m., The DON presented a copy of the facility's current policy titled "Resident Change of Condition". Review of this policy at this time included, but was not limited to: "Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place. Procedure:.. Routine Medical Changes: a. All symptoms and unusual signs will be			

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	documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening....Document resident change in condition and response in the medical record. Documentation will include time and family/physician response..." This Federal Tag was related to Complaint IN00215472. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, record review and interview, the facility failed to ensure privacy was provided during 3 of 3 observations of care. (Resident 42, 60, and 100) and dentures were in place for appearance and ability to eat. (Resident 69) Findings include:	F 0241	1.Residents #42, #60, and #100 were provided privacy by the window blinds being shut, door being closed, and privacy curtain being drawn to where resident would not be visible if someone entered door. Resident #69 received dentures on 1-31-17. 2.All other residents have the potential to be affected. 3.Dressing Change, Perineal	02/10/2017

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	1. On 01/26/17 at 9:52 a.m., CNA (Certified Nursing Assistant) 1 and CNA 2 performed incontinence care on Resident 42. Upon entering the resident's room, CNA 1 pulled the curtain opened three feet facing the side by the bathroom door. The CNAs lowered the head of bed, and pulled the bed away from the wall, which pulled the curtains open to create a six foot area being open from the windows with no coverage. Incontinence care was completed with the privacy curtains left open. 2. On 01/26/17 at 8:53 a.m., Resident 60 was observed receiving catheter care by CNA 3. She entered the resident's room and left the privacy curtains open with a four foot area from the wall to the right of the resident's bathroom door. She completed catheter care with the privacy curtains in the same position. 3. On 01/26/17 at 9:13 a.m., LPN (Licensed Practical Nurse) 1, provided wound care on Resident 100's right thigh. He entered the resident's room, and did not attempt to close the privacy curtains, which were left open by five feet from the wall, on the left side of the bathroom door. The resident's roommate left the room, opening and closing the entry door behind her. Upon observation of the light		Care, and A.M. Care Skills Validations were reviewed with no changes made (See Attachment B, C, and D). The CEC or designee will in-service all nursing staff on the above skills validations by 2-10-17. 4.DNS or designee will monitor weekly using Nursing Monitoring Tool times 4 weeks, monthly times 4 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 90% or above.	

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	drainage on the gauze, the LPN told the resident she could roll onto her back, while he obtained a clean gauze. He returned to the resident's room and leaving the privacy curtains open to the same position, completed the wound care. During an interview, on 01/30/17 at 8:33 a.m., the DON (Director of Nursing) indicated, when providing care, the staff should pull privacy curtains closed and shut the entrance doors. The review of the Indwelling Urinary Catheter Care policy, on 01/30/17 at 8:38 a.m., indicated, but was not limited to, "...2. Provide privacy..."			
F 0250 SS=D Bldg. 00	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, record review and interview the facility failed to provide medically related social services to meet the physical, mental and psychosocial needs of a resident who was without his teeth for over Two months. (Resident 69) Findings include:	F 0250	1.Resident #69 received dentures on 1-31-17. Social Services documented receipt of appliance in the resident's medical record. 2.All residents have the potential to be affected. All resident's dental visits were audited and any resident requiring follow-up was addressed and documented in the resident's	02/10/2017

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	During an observation, on 01/24/2017 at 01:15 p.m., Resident 69 was sitting in his wheelchair in the main dining room eating lunch. He did not have any teeth or dentures in his mouth. The resident was eating a regular diet. His mouth was drawn inward with the appearance of no teeth or dentures. On 01/25/2017 at 3:30 p.m. during a observation and interview with resident 69, he indicated " I believe my teeth have been gone for about two months. I can't eat very well. I would like to have some toast but I can't chew it. The dentist took my teeth when he was here last. He took my impressions and I haven't had teeth since. He said he would bring them back in a few days. No one seems to know anything about my teeth. I really would like to have them back..." The Quarterly MDS (Minimum Data Set) assessment, dated 12/07/2016, indicated Resident 69 had a BIMS (Brief Interview for Mental Status) of 15 and was cognitively alert and oriented. Clinical record review for Resident 69, on 01/25/2017 at 4:06 p.m., indicated there was no documentation found prior to 01/24/17 concerning the resident's dentures. No documentation could be		medical record. 3.Dental Services Policy and Social Service Director Job Description reviewed with no changes made (See Attachments E and F). The Executive Director will in-service the Social Service Director and Memory Care Facilitator on the above items by 2-10-17. SSD and MCF will monitor dental services with MDS assessment calendar to ensure dental services are provided per policy to meet resident needs. SSD and MCF will review dental recommendations after each dental visit and provide weekly follow-up and document in the resident's medical record until all recommendations have been completed. SSD and MCF will also complete an Appointment Tracking Log (See Attachment G). 4.DNS or designee will monitor weekly using Nursing Monitoring Tool times 4 weeks, monthly times 4 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 90% or above.	

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	located to indicate where the resident's dentures were or who had them. During an interview, on 01/24/2017 at 08:42 a.m., Resident 69 indicated " my dentures have been gone for over two months, and I don't know what has happened to them. The staff doesn't know anything about them". During an interview, on 01/26/2017 at 8:15 a.m., the SSD indicated she called the dental company on 01/24/2017. During an interview, on 01/26/2017 at 9:10 a.m., Resident 112, the roommate to Resident 69, indicated " I have been here since November and Resident 69 hasn't had his teeth. At one time the girls told him they didn't know where his teeth were." The Admission MDS assessment, dated 10/05/2016, indicated Resident 112 had a BIMS of 15 and was cognitively alert and oriented. During an interview, on 01/30/2017 at 10:07 a.m., the DNS (Director of Nursing Services) indicated " I have talked to the resident about his teeth. He doesn't want his diet changed. He said I just want my teeth back. He is upset about his teeth. I know his roommate is also upset about			

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	the residents teeth and he has talked to me about it. I just don't know what else to do. SSD takes care of things like this. On 01/30/2017 at 1:00 p.m., the ED (Executive Director) presented a job description of the Social Service Director position description. "The Social Service Director provides medically - related social services to attain or maintain the highest practicable physical, mental, and psychosocial well - being of each resident; and share responsibility toward creating and sustaining an environment that humanizes and individualizes each residents living area." 3.1-34(a)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interviews, the facility failed to follow physician orders for reporting abnormal blood sugars; laboratory blood draws; discontinuation of the Wanderguard; and medications administered per the psychiatrist orders. This deficient practice	F 0282	1.Resident F and G were not harmed. Physician's and Resident Representatives were notified regarding blood sugars exceeding parameters, medication error, laboratory blood draws not obtained as ordered, wander guard bracelet not	02/10/2017

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	affected 2 of 6 residents reviewed for physician orders. (Resident F & G) Findings include: 1. Review of the clinical record for Resident F, on 1/25/17 at 11:15 a.m., indicated the resident had diagnoses which included, but were not limited to: insulin dependent diabetes mellitus, schizoaffective, dementia without behavior disturbance, and anxiety disorder. Review of the physician orders for January 2017 indicated the resident had a standing order dated 11/16/16 for the following: -Accuchecks (to check amount of sugar in the blood) QID (4 times a day) -Novolog (insulin) per sliding scale for blood sugar of 401 to 450 give 15 u (units) and >(greater) than 450 give 18 u and call NP/PA (Nurse Practitioner/Physician Assistant). Review of the Diabetic Administration History, for 11/15/16 through 1/24/17, indicated the resident was above 450 and no MD (Medical Doctor) notification was made for the following dates: - 11/17 at 12:00 noon / BS (Blood Sugar)		discontinued, and psychiatric medications clarified as applicable. 2.All other residents have the potential to be affected. Interdisciplinary team reviewed residents by 2-10-17 and notification is being completed per MD order. 3.Charge Nurse Job Description was reviewed with no changes made (See Attachment H). CEC or designee will in-service licensed nursing staff on the job description by 2-10-17. 4.DNS or designee will monitor weekly using Nursing Monitoring Tool times 4 weeks, monthly times 4 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 90% or above.	

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	of 546 - 11/17 at 4:00 p.m. / BS of 461 - 11/20 at 12:00 noon / BS of 470 - 11/20 at 4:00 p.m. / BS of 490 - 11/23 at 12:00 noon / BS of 467 - 11/30 at 9:00 p.m. / BS of 496 - 12/03 at 9:00 p.m. / BS of 480 - 01/18 at 12:00 noon / BS of 461 Review of the Diabetic Administration History, for 11/17/16 at 6:00 a.m., indicated the resident was given 18 units of Novolog instead of the scheduled 15 units for a BS of 446. No documentation of the NP/PA being notified in the resident's clinical record. During an interview, on 1/26/17 at 1:20 p.m., LPN (Licensed Practical Nurse) 3 indicated "when blood sugar readings are above or below the set parameters, we are supposed to call the MD for new orders." On 11/22/16, the Psychiatrist completed an initial evaluation and ordered a VPA (Valproic Acid) level be drawn. If the VPA level was low, the Psychiatrist was going to increase the resident's medication (Depakote - a medication used for psychosis). Review of the Laboratory tests between 11/22/16 and 1/24/17 indicated no laboratory results could be found for a VPA level.			

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	On 12/12/16, the nursing progress note indicated a new order was received to "D/C [discontinue] Wanderguard" (a bracelet that alerts staff if resident near an exit door). The January 2017 monthly physician orders also noted the Wanderguard was to be discontinued effective 12/12/16. An observation of Resident F, on 1/23/17 at 10:45 a.m. and 1/25/17 at 5:50 p.m., indicated the resident's Wanderguard remained on her right ankle. In an interview, on 1/26/17 at 1:20 p.m., LPN 3 stated "I don't know why the resident still had her Wanderguard bracelet on... but I will find out." During an interview with the Director of Nursing, on 1/30/17 at 10:30 a.m., she indicated the Wanderguard was never really supposed to have been discontinued and did not know why the nurse wrote the order to discontinue the Wanderguard. 2. Review of the clinical record for Resident G, on 1/27/17 at 9:30 a.m., indicated the resident had diagnoses which included, but were not limited to: psychosis not due to a substance or known physiological condition, schizophrenia, recurrent depressive			

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	disorders, vascular dementia with behavioral disturbance. The January 2017 Monthly Physician Orders indicated the resident had the following orders: - 9/16/16 Lantus 25 u (Units) SQ (subcutaneous) HS (at night) - 9/18/16 Novolog SS (sliding scale) Insulin QID (4 times a day) - 9/28/16 Zoloft 50 mg (milligrams) - 1 tablet every AM (morning) - 9/28/16 Zyprexz 2.5 mg - 1 tablet every AM - 9/28/16 Zyprexa 5 mg - 1 tablet every HS On 11/18/16, the pharmacy made a recommendation noting: "Resident has diabetes, but a recent A1c [glycated hemoglobin, amount of sugar in the blood] is not available in the resident's record. Please consider monitoring A1c on the next convenient lab day and then Q [every] 3 months if therapy has changed or goals are not being met, or every 6 months if meeting treatment goals..." On 12/12/16, the Nurse Practitioner accepted the recommendation and implemented the order for an A1c at the next lab day and then every three months.			

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	This order was noted by nursing and was written as "New order received to obtain A1c, ...valporic acid levels q [every] 3 months." The order failed to include an A1c level to be drawn at the next laboratory day. On 12/16/16, the laboratory staff was in the facility to draw resident blood for the physician laboratory orders, but the A1c was not drawn. During an interview, on 1/30/17 at 10:00 a.m., the DON (Director of Nursing) indicated she did not know why the nurse failed to include the A1c in the order to be drawn at the next lab day. On 1/24/17, the psychiatrist wrote new orders for the resident. The new orders were written as: "Increase Zyprexa (for psychosis) to 3 mg Q am and 5 mg Q HS; Zoloft 12.5 mg Q am x 7 days, then increase Zoloft to 25 mg Q am for depression." Review of the current MD orders as of 1/26/17 failed to note the changes having been made or the Zoloft order clarified as the resident was currently on Zoloft 50 mg Q AM. On 1/26/17 at 3:10 p.m., LPN 4 stated when the physician agrees with the pharmacy recommendations, the physician will write an order. If the			

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	physician does not write the order or calls the order to the facility, staff will write out the orders for the physician to sign. An EVENT was opened to show a new order was received. Review of the resident's clinical record failed to document an EVENT being opened or the order written. On 1/27/17 at 10:23 a.m., the DON indicated she was unable to give a reason for the orders not being implemented or clarified. This Federal Tag was related to Complaint IN00215472. 3.1-35(g)(2)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			

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	(iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation and interview, the facility failed to ensure dishes used to serve the residents were clean and dry when stacked for use during 2 of 3 kitchen observations. Findings include: 1. During the lunch meal service observation on 1/23/17 at 12:15 p.m., the Cook was serving the meal with plates located in the heated dish rack. The plates were observed to be wet. When she picked up each plate, she tilted the plates and water dumped onto the next seven plates. In the clean dish stack there was one dinner plate and one sectioned plate with pieces of food debris on the plates. 2. During the supper meal service observation on 1/25/17 at 4:45 p.m., one bottom plate holder and two dinner plates had a small amount of food debris on	F 0371	1.No residents were served food from wet or soiled plates. 2.All residents have the potential to be affected. Residents are receiving food that is distributed in a sanitary manner. 3.Cleaning Dishes and Dish Machine, Handling Clean Equipment and Utensils, and Duties of Person in Charge Policy and Procedures reviewed with no changes made (See Attachment I, J, and K). The Dietary Manager or designee will in-service all dietary employees of the above policies by 2-10-17. 4.Dietary Manager or designee will complete a Dietary Sanitation Tool weekly times 4 weeks, monthly times 4 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters (See Attachment L). The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the	02/10/2017

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	them, and one dinner plate in the heated dish holder was wet. During an interview with the Dietary Manager on 1/30/17 at 9:05 a.m., she indicated "Staff are supposed to let the plates air dry after coming out of the dish machine and are not suppose to stack them until dry. I have new people in the dietary department whom I am going over the protocols with so they learn. Wet dishes did happen and I am teaching the new people." 3.1-21(i)(2) 3.1-21(i)(3)		above plan will be altered accordingly if the threshold is not 90% or above.	