STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.This visit included the investigation of Complaints Nursing home complaint IN00239535, Residential complaint IN00241129 and Nursing Home IN00247584. Nursing Home Complaint IN00239535 - Unsubstantiated due to lack of evidence. Residential Complaint IN00241129 - Substantiated. State deficiency related to allegation is cited at R144 Nursing Home Complaint IN00247584 - Substantiated. No deficiencies related to allegations are cited. Survey dates: January 29, 30, 31, February 1, 2, 5, 6, and 7, 2018 Facility number: 001149 Provider number: 155618 Aim Number: 200145500 Census bed type: SNF: 10 SNF/NF: 30 Residential: 69 Total: 109 Census payor type: Medicare: 10 Medicaid: 22 Other: 8 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The statements made in this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction. This Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.** **Summer Trace respectfully requests desk review for deficiencies noted.**	

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

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	Quality Review was completed on February 15, 2018.			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's			

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	medical, social, and administrative records in accordance with State law. Based on observation, interview and record review the facility failed to provide privacy during patient care for 1 of 1 residents observed for privacy. (Resident 7) Finding includes: Resident 7's record was reviewed on 02/02/18 at 11:50 a.m. Diagnoses included, but were not limited to, quadriplegia, paralytic syndrome following cerebrovascular disease and mononeuropathy. On 02/06/18 at 10:10 a.m., Resident 7 was observed from the hallway, through the open door, laying in a high positioned bed. The bed sheet was pulled down to his ankles. Resident 7's gown was pulled up over his waist exposing his legs and blue brief. The privacy curtain was not pulled closed. At that time, CNA 5 returned to the room. CNA 5 indicated she was in the middle of providing patient care to Resident 7 and had to leave the room to get supplies. CNA 5 indicated she should have covered the resident before leaving his room. During an interview on 02/06/18 at 11:29 a.m., the Clinical Support Nurse, indicated they did not have a specific policy on privacy it was part of morning care. A current procedure titled "...AM Care...." provided by the Clinical Support Nurse on 02/06/18 at 11:00 a.m. The procedure indicated, "...4...provide privacy...."	F 0583	**Corrective actions accomplished for resident found to be affected by this alleged practice** Curtain was pulled and privacy was provided for Resident #7. **Other residents having the potential to be affected by this alleged deficient practice** Residents requiring total assist with personal care. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** Nursing staff have been educated by the DON regarding privacy and dignity. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** DON/Designee will observe personal care by nursing staff three times a week x 4 weeks, twice a week x4 weeks, weekly x4 weeks and as needed thereafter. **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial	03/09/2018

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	3.1-3(p)(4)		compliance	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review the facility failed to comply with mandatory reporting of an injury of unknown origin for 1 of 1 resident observed for injury of unknown origin. (Resident	F 0609	**Corrective actions accomplished for resident found to be affected by this alleged practice.**	03/12/2018

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	1) Finding includes: Resident 1's record was reviewed on 02/02/18 at 3:17 p.m. Diagnoses included, but were not limited to, anemia, Alzheimer's Disease and pathological fracture of hip. A nurse's note, dated 01/27/18, indicated a CNA reported a laceration to Resident 1's right lower extremity. The laceration was noted to be 10.6 cm (centimeters) (length) by 3 cm (width) with fatty tissue exposed. A nurse's note, dated 01/27/18, indicated Resident 1 was sent to the emergency department for treatment of the laceration and the resident did not have enough skin to close the wound. During an interview, on 02/02/18 at 12:32 p.m., the DON (Director of Nursing) was unable to produce any skin assessment sheets for the injury. During an interview on 02/02/18 at 2:13 p.m., the Clinical Support Nurse indicated the laceration measuring 10.6 cm by 3 cm with exposed fatty tissue was an injury of unknown origin and she did not feel the injury needed to be reported because she had not identified the injury to be of a suspicious origin. 3.1-28(c)		Injury on resident #1 was reported to ISDH. **Other residents having the potential to be affected by this alleged deficient practice.** Residents with injuries requiring additional treatment. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** Nursing staff have been educated by the DON to report all injuries requiring additional treatment to the DON and Administrator. DON and Administrator have been educated by the QAC to report all injuries requiring additional treatments to ISDH. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** The Director of Nursing / Designee will observe reported injuries upon review of 24hour reports and incident reports. Regional support team will be notified of any concerns that may be considered a reportable incident. Suspicious injuries and injuries requiring additional treatment will be reported to ISDH, per ISDH Abuse Reporting Policy. Regional Support Team will be notified of reportable incidents, to include follow up, as investigation is completed. **What quality assurance**	

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			program will be put into place. Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review the facility failed to apply palm protectors in accordance with the resident's care plan for 1 of 1 resident observed for splints and braces. (Resident 7) Finding includes: Resident 7's record was reviewed on 02/02/18 at 11:50 a.m. Diagnoses included, but were not	F 0688	**Corrective actions accomplished for resident found to be affected by this alleged practice.** Palm protectors for Resident #7 were obtained and applied. **Other residents having the potential to be affected by this alleged deficient practice.**	03/09/2018

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	limited to, quadriplegia, paralytic syndrome following unspecified cerebrovascular disease and apraxia. The medication administration record for January 2018, provided by the Clinical Support Nurse on 02/06/18 at 11:00 a.m., indicated palm protectors were in place on 01/30/18 and 01/31/18. A current care plan provided by the Clinical Support Nurse, on 02/06/18 at 11:00, indicated "...needing to wear palm protectors to maintain ROM (range of motion)...palm protectors to bilateral hands at all times every shift...." On 01/30/18 at 9:12 a.m., Resident 7 was observed resting in bed with a wash cloth in his left hand and no palm protector on his right hand. On 01/31/18 at 8:52 a.m., Resident 7 was observed resting in bed with a wash cloth in his left hand and no palm protector on his right hand. On 01/31/18 at 3:59 p.m., Resident 7 was observed up in his Broda chair with a wash cloth in his left hand and no palm protector on in right hand. On 02/01/18 at 8:51 a.m., Resident 7 was observed resting in bed with a wash cloth in his left hand and no palm protector on his right hand. On 02/02/18 at 9:37 a.m., Resident 7 was observed resting in bed with a wash cloth in his left hand and no palm protector on his right hand. On 02/02/18 at 1:58 p.m., Resident 7 was observed resting in bed with a wash cloth in his left hand and no palm protector on his right hand. On 02/05/18 at 9:50 a.m., Resident 7 was observed		Residents requiring the use of splints and palm protectors. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** House wide audit to identify residents needing/requiring splints/palm protectors. Nursing staff have been educated by the DON to ensure splints and palm protectors are applied as ordered. Nursing staff have been educated by the DON to notify therapy staff when splints/palm protectors are unavailable. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** The Director of Nursing / Designee will observe for appropriate splint/palm protector placement three times per week x 4 weeks, twice a week x4 weeks, weekly x 4 weeks and as needed thereafter. **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	

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	resting in bed with a wash cloth in his left hand and no palm protector on his right hand. During an interview, on 02/05/18 at 9:50 a.m., CNA 3 indicated she believed Resident 7 had 2 palm protectors. During an interview, on 02/05/18 at 10:01 a.m., LPN 2 indicated they had a couple of different palm protectors used for residents but if they did not have a palm protector they rolled up a wash cloth and put it in the residents hand. During an interview, on 02/05/18 at 11:04 a.m., COTA 6 (Certified Occupational Therapy Assistant) indicated therapy encouraged the use of palm protectors, not wash cloths, as palm protectors were better. There were currently at least 6 palm protectors in storage and nurses also had palm protectors in their storage areas. On 02/05/18 at 4:00 p.m., Resident 7 was observed resting in bed without a palm protector in his left or right hands. A current nursing procedure, provided by the Clinical Support Nurse on 02/06/18 at 11:00 a.m., titled "...Braces/Splints...." indicated, "...7. Apply device as directed by therapist or physician...9. Follow wear schedule as outlined by therapist or physician...." 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure a residents were free of accidents and accident hazards for 3 of 4 residents observed for accidents. (Resident 7, Resident 1, and Resident 4) Findings include: 1. Resident 7's record was reviewed on 02/02/18 at 11:50 a.m. Diagnoses included, but were not limited to, quadriplegia, paralytic syndrome following unspecified cerebrovascular disease and apraxia. A current care plan provided by the Clinical Support Nurse , on 02/06/18 at 11:00 a.m., indicated "...At risk for falls due to involuntary movements...bed in low position...." On 02/05/18 at 4:00 p.m., Resident 7 was observed alone, in his room, laying in a high positioned bed. At that time, LPN 4 entered the room and indicated Resident 7's bed was suppose to be in a low position. On 02/06/18 at 10:10 a.m., resident was observed from the hallway, through the open door, laying in a high positioned bed. At that time, CNA 5 returned to the room. CNA 5 indicated she was in the middle of providing patient care to Resident 7 and had to leave the room to get supplies. She indicated Resident 7's	F 0689	Corrective actions accomplished for resident found to be affected by this alleged practice. Fall interventions of low bed were removed from the care plan of Resident #7 and Resident #4. Resident #7 does not turn self or reposition in bed. Resident #4 staff was educated on the importance of following careplan. Resident #4's bed is to be in low position to reduce risk of injury due to falls. CNA #9 educated on the use of a gait belt and resident #4 was changed to mechanical lift for transfers. Resident #1 received a diagnosis of fragile skin, transfer status changed to mechanical lift and received padding to her w/c. Other residents having the potential to be affected by this alleged deficient practice. Residents requiring total assistance with transfers. Residents at risk for increased incidence of skin tears. Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.	03/12/2018

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	bed is always in a high position. 2. Resident 1's record was reviewed on 02/02/18 at 3:17 p.m. Diagnoses included, but were not limited to, anemia, Alzheimer's Disease and pathological fracture of hip. On 02/05/18 at 10:08 a.m. Resident 1 was up in her wheelchair in the common area, she had a dressing to her left lower leg and ace wraps on both her arms. The admission/readmission screen, dated 9/17/17, provided by the Clinical Support Nurse on 02/06/18 at 11:00 a.m., indicated Resident 1 had no skin integrity issues present on admission. A nurse's note, dated 10/05/17, indicated Resident 1 had a scabbed area on her right lower arm that was reopened during bed time care. A nurse's note, dated 10/09/17, indicated Resident 1 had a scabbed area on her right upper thigh that was reopened during bed time care. The area required steri-strips to close. A nurse's note, dated 11/15/17, indicated Resident 1 had a wound on her right popliteal (behind knee). A nurse's note, dated 11/24/17, indicated Resident 1 sustained a wound measuring 4 cm (centimeters) during a transfer. A nurse's note, dated 12/17/17, indicated Resident 1 was observed with a skin tear on her right hand measuring 1.6 cm. A nurse's note, dated 12/22/17, indicated a CNA		House wide audit to review fall and skin care plans. Nursing staff have been educated by the DON to ensure all fall interventions are in place. Nursing staff have been educated by the DON to notify nurse managers if interventions are no longer effective or necessary. Nursing staff have been educated by the DON on gait belt use. IDT will review falls and skin alterations daily for new or replacement interventions. How this corrective action will be monitored to ensure the alleged deficient practice will not recur. Fall and safety interventions will be reviewed with each incident by the IDT. DON/Designee will audit three times per week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and as needed thereafter. IDT will review and update careplans quarterly per schedule. Gait belt audits by the DON/Designee, three times per week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and as needed thereafter. What quality assurance program will be put into place.	

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	(Certified Nursing Assistant) reported a skin tear, that she noticed on Resident 1's right forearm, while she was assisting the resident. The skin tear was noted to be 6 cm long. A nurse's note, dated 01/17/18, indicated Resident 1 sustained a skin tear to her right upper arm. A nurse's note, dated 01/26/18, indicated the skin tear to the left upper arm was reopened. Steri-strips were applied to the wound. A nurse's note, dated 01/27/18, indicated a CNA reported a laceration to Resident 1's right lower extremity. The laceration was noted to be 10.6 cm (length) by 3 cm (width) with fatty tissue exposed. A nurse's note, dated 01/27/18 indicated the resident was sent to the emergency department for treatment of the laceration and the resident did not have enough skin to close the incision. During an interview on 02/02/18 at 12:32 p.m., the DON (Director of Nursing) was unable to produce any skin assessment sheets. During an interview on 02/02/18 at 2:13 p.m., the Clinical Support Nurse indicated the laceration measuring 10.6 cm by 3 cm was an injury of unknown origin.3. During an observation on 02/01/18 at 9:29 a.m., Resident 4's bed was in high position from the floor. During an observation on 02/01/18 at 11:24 a.m., Resident 4's bed was in high position from the floor. During an observation on 02/01/18 at 4:22 p.m., Resident 4's bed was in high position from the floor.		Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	

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During an observation on 02/05/18 at 11:02 a.m., CNA 9 was observed transferring Resident 4 into bed from her wheelchair. CNA 9 placed one of her hands under Resident 4's arm pit and her other hand was holding onto the back of Resident 4's pants.

Resident 4's record was reviewed on 02/02/2018 at 10:44 a.m. Diagnoses included, but were not limited to, hypertension, dementia and hyperlipidemia.

A care plan dated 06/20/2017 indicated Resident 4 was at risk for falls. Interventions included, but were not limited to, keeping the bed in lowest position.

A CNA report sheet, provided by the Director of Nursing on 01/29/2017 at 2:23 p.m., indicated for resident safety the bed should be in the lowest position.

During an interview, on 02/05/2018 at 11:11 a.m., CNA 9 indicated she should have used a gait belt when transferring Resident 4.

During an interview, on 02/05/2018 at 11:39 a.m., the Director of Nursing indicated her expectations of the CNA's were to use a gait belt when transferring a resident for the resident's safety.

A current policy titled "Gait Belt" dated 12/2009, provided by the Director of Nursing on 02/05/2018 at 2:00 p.m., indicated "...purpose: to safely and effectively transfer...a patient...."

3.1-45(a)(1)
3.1-45(a)(2)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to maintain aseptic procedure during tracheostomy care for 1 of 2 residents observed for respiratory care (Resident 18), and failed to provide supervision during a breathing treatment for 1 of 2 residents observed for respiratory care. (Resident 34). Findings include: 1. The record for Resident 18 was reviewed on 01/31/18 at 10:05 a.m. Diagnoses included, but were not limited to, tracheostomy status, seizures and obstructive hydrocephalus. A current physician's order indicated change the inner cannula twice a day. During an observation on 02/02/18 beginning at 6:27 a.m., LPN 2 (Licensed Practical Nurse) reviewed the physician's order for an inner cannula change. She then proceeded to Resident 18's room, knocked on the door, introduced herself and explained the reason for her visit. LPN 2 washed her hands, put on gloves and removed the inner cannula and soiled dressing from Resident 18's tracheostomy site. She disposed of	F 0695	**Corrective actions accomplished for resident found to be affected by this alleged practice**. Staff members were educated on hand hygiene with glove use during trach care and nebulizer administration. Resident #34 was assessed for self-administration for meds and order obtained for self-administration for nebulizer treatment. Careplan was updated. **Other residents having the potential to be affected by this alleged deficient practice.** Residents requiring trach care and neb treatments. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** Nursing staff have been educated by the DON on hand hygiene and glove use. Licensed staff have been educated	03/09/2018

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	the cannula, soiled dressing and her gloves in a trash can. Without performing hand hygiene, LPN 2 set the tracheostomy kit on the bedside table, opened the package, reached into the sterile package and removed the sterile gloves. She then put on her sterile gloves and proceeded to complete the procedure. During an interview on 02/02/18 at 6:38 a.m., LPN 2 indicated she did not need to wash or sanitize her hands between removing soiled gloves and applying sterile gloves. She had read the policy on tracheostomy care/change. A current procedure provided by the DON (Director of Nursing) on 02/02/18 at 11:31 a.m., titled "...Tracheostomy Care...." indicated, "...9. Remove and discard soiled dressing. 10. Remove gloves and perform hand hygiene...."2. On 1/30/2018 at 10:55 a.m., Resident 34 was observed in bed watching television. His nebulizer mask with the medication chamber attached was resting on top of his sheets, the machine was still on and the medication chamber was empty. During an interview at that time, Resident 34 indicated LPN 1 put his breathing medication in the chamber attached to his mask, handed him the mask and left the room. The record for Resident 34 was reviewed on 01/31/2018 at 10:00 a.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease). The Medication Administration Record for January indicated Resident 34 received DuoNeb solution (a medication used to improve breathing) 0.5-2.5 (3) mg/ml (milligrams/milliliters) four times a day for COPD.		by the DON on trach care and nebulizer treatments. House wide audit of residents who self-administer nebulizer treatments, assessments completed, orders obtained, and careplans updated. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** DON/designee will observe trach care and nebulizer treatments three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and as needed thereafter **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	

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	During an interview on 01/30/2018 at 11:23 a.m., LPN 1 indicated she should have stayed in Resident 34's room while he was receiving this medication unless the resident had an order and an assessment to self administer medication. The Director of Nursing could not provide a self administer medication order or assessment for Resident 34. A current policy dated 11/2017 titled, "...Medication Administration: Self-Administration Of Medications...." received from the Director of Nursing on 01/30/2018 at 1:42 p.m., indicated, "...The decision to allow a patient to self-administer medication(s) is subject to periodic assessment...." 3.1-47(a)(4) 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review the facility failed to obtain a physician's order for dialysis treatment and failed to establish a method of communication with dialysis facility for 1 of 1 residents reviewed for dialysis care. (Resident 201) Finding includes: The record for resident 201 was reviewed on	F 0698	**Corrective actions accomplished for resident found to be affected by this alleged practice**. Physician order was obtained for Resident #201. **Other residents having the potential to be affected by this alleged deficient practice.**	03/09/2018

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	02/02/2018 at 2:19 p.m. Diagnoses included, but were not limited to, sepsis, type 2 Diabetes Mellitus, dependence on renal dialysis, heart failure, and acute kidney failure. A care plan, dated 01/22/2018, provided by CSN (Clinical Support Nurse) on 02/06/2018 at 11:58 a.m., indicated Resident 201 required dialysis to treat end stage renal (kidney) disease. The record did not contain a Physician's order for dialysis treatment. During an interview on 01/29/2018 at 1:50 p.m., the ED (Executive Director) indicated the facility did not have a service contract or a dialysis communication book for Resident 201. During an interview with the DON (Director of Nursing) and the ED, on 02/02/2018 at 4:01 p.m., the DON indicated they should have had a service contract and a dialysis communication book to ensure resident 201 received all necessary care. 3.1-37(a)		Residents requiring dialysis treatments. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** DON has educated licensed staff on obtaining orders for dialysis and dialysis communication forms. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** DON/designee will audit for dialysis orders and completion of dialysis communication forms three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and as needed thereafter **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including			

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	duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review the facility failed to monitor and document blood pressures per physician orders for a resident on a medication to control high blood pressure for 1 of 5 residents reviewed for unnecessary medications. (Resident 6). Findings include: Resident 6's record was reviewed on 02/1/2018 at 3:21 p.m. Diagnoses included, but were not limited to, hypertension, anxiety disorder and vascular dementia. A physician's order, dated 09/16/2017, indicated metoprolol (a medication used to treat high blood pressure) 25 mg (milligrams) two times a day, hold medication for systolic blood pressure (the top number of a blood pressure reading) less than 110. The January Medication Administration Record indicated Resident 6 received all scheduled doses of metoprolol 25 mg.	F 0757	**Corrective actions accomplished for resident found to be affected by this alleged practice .** Supplementary documentation added to the order. Order was modified in the EMR to cue the nurse on-duty to enter and follow parameters. **Other residents having the potential to be affected by this alleged deficient practice.** Residents on blood pressure medication requiring monitoring. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** House wide audit on residents with medication requiring monitoring. License staff educated by the DON	03/09/2018

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	A blood pressure summary for Resident 6, provided by the Director of Nursing on 02/06/2018 at 11:00 a.m., indicated 3 blood pressure readings were documented for January. During an interview at that time, the Director of Nursing indicated she could not provide anymore blood pressure readings and nursing staff should have taken and documented blood pressures twice a day with this medication adminitration as ordered by the physician. 3.1-48(a)(4)		on following physician orders. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** DON/designee will audit for monitoring and documentation three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks and as needed thereafter **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used			

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	psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility failed to provide an appropriate diagnosis for psychotropic medications prescribed to residents with dementia, failed to monitor for side effects, and targeted behaviors for psychotropic medications and address Gradual Dose Reductions for 4 of 5 residents reviewed for unnecessary medications. (Resident 43, 23, 6 and	F 0758	**Corrective actions accomplished for resident found to be affected by this alleged practice.** Care plans updated to include potential side effects and targeted behaviors for resident #'s 6, 23, 35, and 43.	03/09/2018

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	35) Findings include: 1. The record for resident 43 was reviewed on 02/02/2018 at 4:08 p.m. Diagnoses included, but were not limited to, dementia, type 2 Diabetes Mellitus, metabolic encephalopathy, and kidney disease. Physician's orders included, but were not limited to: Aricept tablet (a medication to treat dementia) give 10 mg by mouth at bedtime for psychotropic. Dated 12/15/2017 duloxetine capsule (an anti-depressant) give 30 mg by mouth one time a day for psychotropic. Dated 12/15/2017 lorazepam tablet (an anti-anxiety) 0.5 mg give 1 tablet by mouth two times a day for anxiety. Dated 12/23/2017 No orders were included to indicate what side effects and behaviors should have been monitored by nursing staff for the above administered medications. A review of Resident 43's complete care plan indicated the targeted behaviors and side effects of her psychotropic medications were not addressed.2. The record for Resident 23 was reviewed on 02/01/18 at 1:15 p.m. Diagnoses included, but were not limited to, depressive disorder, dementia without behavioral disturbance, and encephalopathy. A Physician's order, dated 06/14/2017, indicated olanzapine (an anti-psychotic medication) 5 mg one time a day for the treatment of resistant-major depressive disorder.		Appropriate diagnosis obtained for resident #'s 6 and 43. Note from outside psych documented decline of GDR will be obtained for resident #6 **Other residents having the potential to be affected by this alleged deficient practice.** Residents on psychotropic medications with a dementia diagnosis. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** House wide audit on residents with psychotropic medications for appropriate diagnosis, care plans to observe for side effects and specific behaviors documentation of GDRs. Deficiencies corrected, and careplans updated. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** Social services will audit for monitoring and documentation three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks and as needed thereafter **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified	

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	A Physician's order, dated 11/02/2017, indicated escitalopram (a medication used to treat depression) 20 mg one time a day for the treatment of resistant-major depressive disorder. A care plan, dated 06/24/2017, indicated Resident 23 was at risk for changes in mood related to depression. Interventions included, but were not limited to, assess for physical/environmental changes that may precipitate change in mood. There were no specific environmental changes or specific targeted depression behaviors documented anywhere in the medical record. A care plan, dated 10/16/2017, indicated Resident 23 was at risk for adverse effects related to the use of anti-psychotic medications. Interventions included, but were no limited to, evaluate effectiveness and side effects of these medications. There were no specific side effects of these medications documented in the medical record. 3. The record for Resident 6 was reviewed on 02/01/2018 at 3:21 p.m. Diagnoses included, but were not limited to anxiety disorder, vascular dementia, major depressive disorder, and bipolar disorder. A physician's order, dated 11/02/2017, indicated lorazepam (a medication used to treat anxiety) 0.5 milligrams twice a day for anxiety. A physician's order, dated 12/29/2017, indicated olanzapine 10 milligrams at bed time for mood disorder. A physician's order, dated 09/16/2017, indicated		deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	

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	vilazodone (a medication used to treat depression) 40 milligrams once a day for depression. A care plan, dated 01/09/2018, indicated Resident 6 was a risk for changes in mood related to bi-polar disease, depression and anxiety. Interventions included, but were not limited to, assess for physical/environmental changes that may precipitate change in mood. There were no specific targeted behaviors or specific environmental changes to monitor, for the use of these medications documented in the medical chart. A progress note, dated 10/18/2017, written by the consultant pharmacist, indicated she recommended a trial dose reduction of Resident 6's antipsychotic medications. On 11/03/2017 a note from the Nurse Practitioner indicated Resident 6's daughter did not want to trial this recommendation because Resident 6 sees an outpatient psychiatric service that was contacted on 11/22/2017. A psychotherapy progress note, from [name of company] dated 11/26/2017, did not show documentation of a gradual dose reduction being addressed as recommended by the pharmacy consultant on 10/18/2017. During an interview on 02/05/2018 at 2:30 p.m., the Director of Nursing indicated she could not provide a rational from the physician explaining why a gradual dose reduction was not attempted for Resident 6's anti-psychotic medications. During an interview on 02/06/2018 at 11:07 a.m., the Director of Nursing indicated the diagnosis of depression for Resident 23's use of an antipsychotic medication was not an appropriate,			

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	and the use of psychotropic as a diagnosis for Resident 43's medications was not a valid diagnosis, just a medication classification. 4. The record for Resident 35 was reviewed on 02/01/18 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety disorder, edema and type 2 diabetes. Physician's orders included, but were not limited to, buspirone (a medication for anxiety) 5 mg. No orders were included to indicate what behaviors should have been monitored by nursing staff for the buspirone medication. The facility was unable to provide a care plan indicating what target behaviors should be monitored for buspirone. During an interview on 02/06/18 at 3:11 p.m., the SSD (social services director) indicated residents who resided at the facility and were prescribed psychotropic medications should have had one care plan to address high-risk medication side effects and one to address resident specific behaviors. 3.1-48(a)(3) 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review the facility failed to dispose of a discontinued medication, failed to monitor medication refrigerator temperatures for 1 of 2 medication carts and 1 of 1 medication storage rooms observed for medication storage and labeling. Findings include: 1. During an observation of the second floor east medication cart, on 02/05/18 at 11:24 a.m., with LPN 1 (Licensed Practical Nurse) the following items were found: One- 5 ml (milliliter) bottle of atropine (used to dilate the eye) 1% drops was found in the top drawer. At that time LPN 1 indicated the atropine drops had been discontinued and should have been	F 0761	**Corrective actions accomplished for resident found to be affected by this alleged practice .** Discontinued medication discarded. PPD solution discarded. New PPD solution opened and dated. **Other residents having the potential to be affected by this alleged deficient practice.** Residents with discontinued medication. New admissions. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** Licensed staff educated by DON/designee to pull meds from the	03/09/2018

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	removed from the cart. 2. During an observation of the first floor medication storage refrigerator, on 02/06/18 at 1:39 p.m., with LPN 10 the following items were found: One 1 ml bottle of tuberculin purified protein (a vaccine for tuberculosis testing) with no open date. Three 10 vile boxes of fluzone influenza vaccines Two 10 vile boxes of Afluria influenza vaccines The refrigerator temperature log, on the front of the refrigerator, indicated the refrigerator temperature was to be taken two times each day in the a.m. and p.m. if storing vaccines. A facility document titled, "...Medication/Vaccine Refrigerator Temperature Log...." for the first floor medication room was provided by the DON (Director of Nursing) on 02/06/18 at 2:53 p.m. The log indicated no p.m. temperatures were recorded on 02/01/18, 02/02/18, 02/03/18, 02/04018 or 02/05/18. 3.1-25(m) 3.1-25(o)		med cart upon discontinuing. Meds are to be placed in the med room and sent back to the pharmacy by night shift. Night shift educated by DON/designee to run discontinued medication reports and ensure discontinued medications are removed from the med cart. Licensed staff have been educated by the DON/designee to check medication refrigerators for expired and undated medications in the refrigerators. Expired and undated meds are to be discarded. Licensed staff have been educated by the DON/designee to complete temp logs twice a day on med room refrigerators. Day and Night shift each to complete temp logs on the medication room refrigerator temp log. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur.** DON/designee will audit for discontinued medication, refrigerator temp logs, and medication dating/labeling three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks and as needed thereafter. **What quality assurance program will be put into place.** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected	

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			immediately and maintained as part of QA&A until there is substantial compliance	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the dishwasher wash temperature was maintained and the correct amount of sanitizer was used in the three compartment sink according to the manufacturer's guidelines for the sanitizing of dishes and utensils. This deficient practice had the potential to affect 37 of 40 residents who received food from the kitchen.	F 0812	Corrective actions accomplished for residents found to be affected by this alleged practice. Dishwasher was converted to chemical sanitation, until malfunction was identified and repaired. Three compartment sink was drained and was re-filled with the	03/12/2018

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	Findings include: 1. During an observation of the kitchen with the FSD (Food Service Director) on 01/29/2018 at 10:17 a.m., the dishwashing machine wash cycle reached 155 degrees Fahrenheit. During an interview at that time, the FSD indicated the wash cycle did not reach 160 degrees Fahrenheit to properly wash and sanitize the dishes and utensils. 2. During an observation of the 3 compartment sink, the FSD tested the sanitizer concentration of the third sink by immersing a QT-40 test strip into the water for 40 seconds and then compared the color to the packaging. The color of the strip indicated there was not any sanitizer in the water. The FSD indicated the concentration of the sanitizer should be at 200 to 400 ppm (parts per million) and the third sink of the 3 compartment sink did not have any sanitizer in the water. A current policy titled "...Dishwasher Operation, High Temperature Machine...." dated 9/2014, provided by the Executive Director on 1/29/18 at 1:50 p.m., indicated "...Wash temperatures are to be...160 degrees for conveyor type machines...." A current undated policy titled "...Inservice-Three compartment Sink...." provided by the Executive Director on 1/29/2018 at 1:50 p.m., indicated, "...Sanitizer in the third compartment insures that bacteria are destroyed...test sanitizer concentration...requires a concentration of 200-400 ppm to be effective...." 3.1-21(i)(3)		correct sanitizer solution. Other residents having the potential to be affected by this alleged deficient practice 37/40 residents could potentially be affected. Measures put into place /systemic changes made to ensure the alleged deficient practice does not reoccur. Dietary staff educated by Food Services Director on proper temperature monitoring for dishwasher system. Dishwasher was found to have a loose connection, and was repaired. Dishwasher holds proper temperature. Dietary staff educated by Food Services Director on the proper procedure for the 3 compartment sink and sanitizer concentration. Dietary staff educated by Food Services Director to ensure all monitoring items are in place, to be used to test the solution. How this corrective action will be monitored to ensure the alleged deficient practice will nor reoccur. For the Dishwasher system: Administrator/designee will perform random monitoring, 3 times per day, 5 days per week, for 4 weeks. Food Services Director/designee will continue to monitor, 3 times per day. For three compartment sink: Administrator/designee will perform random monitoring, 3 times per day, 5 days per week,	

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			for 4 weeks. Food Services Director/designee will continue to monitor, 3 times per day. What quality assurance program will be put into place. Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review the facility failed to maintain infection control standards while transporting linens for 2 of 2 random observations (room 221, 222 and 228) and failed to perform hand hygiene before and after providing direct patient care and when changing gloves for 1 of 2 personal care observation (Resident 7). Findings include: 1. During an observation on 01/30/18 at 9:27 a.m., CNA (Certified Nurses Aid) 7 retrieved clean towels and wash cloths from the linen closet and was observed pressing them to her chest. At that time, CNA 7 indicated she was never informed that clean linen should not be held against her body. CNA 7 proceeded to take the linen to room 222. The linen was not covered for transport. 2. During an observation on 01/30/18 at 9:34 a.m., CNA 5 removed flat and fitted sheets for 3 beds from the clean linen closet. She held the clean linen up against her uniform. CNA 5 indicated at this time, she should not have held the linen against her clothing but she was in a hurry and she needed to get the linen to her rooms and to another CNA. The linen was not covered for transport. During an interview with CNA 5 on 01/30/18 at 9:44 a.m., she indicated she took the bed linens to rooms 222, 228 and room 221.	F 0880	**Corrective actions accomplished for resident found to be affected by this alleged practice** C.N.A. #7 is no longer employed. C.N.A. #5 was educated. LPN #8 was educated. **Other residents having the potential to be affected by this alleged deficient practice** All residents have potential to be affected by this alleged deficient practice. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff educated by the DON/designee on transportation of linens and on hand hygiene. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** DON/designee will observe for safe linen handling and infection control three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks and as needed thereafter.	03/09/2018

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	3. During a resident care observation, for Resident 7, on 01/30/18 beginning at 9:48 a.m., LPN 8 washed her hands, donned (put on) gloves and was assisting with patient care. She dropped a package of razors on the floor, picked them up with her gloved hands and placed them on the bedside table. She then proceeded to pull the corners of a soiled fitted sheet off of an occupied bed. LPN 8 then moved to the head of the bed, took a wash cloth and began to wash the right arm and side of Resident 7. LPN 8 then stopped washing resident and began opening drawers of the built in dresser to find a bag. She placed the bag at the foot of the bed and then removed her gloves and discarded them in the trash. During an interview on 01/30/18 at 10:05 a.m., LPN 8 indicated she should have changed gloves between tasks. A current policy, provided by the DON (Director of Nursing) on 01/30/18 10:10 a.m., titled "...Laundry Services...." indicated, "...cover clean linen for protection from contamination during transport...." A current policy, provided by the DON on 1/30/18 at 10:10 a.m., titled "...Personal Protective Equipment...." indicated, "...change gloves after each patient contact...wash hands or use waterless hand sanitizer after removal of gloves...." 3.1-18(a)		**What quality assurance program will be put into place** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	**The statements made in this plan of**	

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	Survey. This visit included a Recertification and State Licensure Survey. This visit included the investigation of Complaints Nursing home complaint IN00239535, Residential complaint IN00241129 and Nursing Home IN00247584. Nursing Home Complaint IN00239535 - Unsubstantiated due to lack of evidence. Residential Complaint IN00241129 - Substantiated. State deficiency related to allegation is cited at R144 Nursing Home Complaint IN00247584 - Substantiated. No deficiencies related to allegations are cited. Survey dates: January 29, 30, 31, February 1, 2, 5, 6, and 7, 2018 Facility number: 001149 Residential Census: 69 These state Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on February 15, 2018.		**correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction. This Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.** **Summer Trace respectfully requests desk review for deficiencies noted.**	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview the facility failed to maintain a clean environment, failed to repair damaged drywall and wallpaper, failed to ensure a door leading outside would close completely, and failed to identify and remove medications from the floor of common areas in the	R 0144	Facility failed to meet this RULE as evidence by: the facility failed to ensure based on observation and interview the facility failed to maintain a clean environment, failed to repair damaged drywall	03/09/2018

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	facility. The deficient practice had the potential to affect 69 of 69 resident's residing in the facility. Findings include: 1. During an observation of the third floor unit C on 02/07/2018 at 1:58 p.m., with the DM (Director of Maintenance) in attendance the following was observed: The wall above the left side fire door, front and back, was noted to have pealing wallpaper, crumbling dry wall and a black substance covering a portion of the wall and the underside of the wallpaper. At the end of the hallway the window box dry wall, starting at the bottom of the right side coroner extending upward, was noted to have peeling wallpaper , crumbling dry-wall and a black substance covering a portion of the wall and the underside of the wallpaper. During an interview at that time, the DM indicated the dry wall in those areas needed to be replaced. The facility use of wallpaper made it difficult to identify all areas of concern. 2. During an observation of the facility, on 01/29/18 at 1:43 p.m., a brick red, oblong tablet was found laying on the floor of the lobby/reception area. The tablet was imprinted with "5 mg" on one side and had a square like design on the other side. During an interview, with the DON (Director of Nursing) on 01/29/18 at 1:40 p.m., she indicated the tablet was Ambien (a sleeping pill) 5 mg (milligrams) and could have been from a visitor. 3. During an observation of the third floor unit, on 02/01/18 at 12:02 p.m., a white round tablet was found laying on the floor to the right of the water		and wallpaper, failed to ensure a door leading outside would close completely, and failed to identify and remove medications from the floor of common areas in the facility. **Corrective actions accomplished for residents found to be affected by this alleged practice.** Wallpaper and drywall: Identified areas were repaired. Door leading outside: Weather stripping was installed between double doors to ensure no gap between doors leading to patio, outside. Medications were removed from the areas immediately. Medication found on 3rd floor was identified. The Medication Administration Report for residents identified was reviewed. The identified residents did not have this medication since December, 2017. The medication on 1st floor was found at the entrance to the facility, a common area where multiple people pass daily. Items found in common area were disposed of properly. Trash receptacles are available on every floor, in common areas. Carpet roll identified was removed from the hallway. **Other residents having the potential to be affected by this alleged deficient practice** All residents have potential to be affected by this alleged deficient	

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	cooler in the common area. The tablet was imprinted with "an627". On the top of the water cooler was a 1.93 ounce bottle of 5 hour energy (an energy drink) with approximately 10 ml (milliliters) in the bottle and one bottle of grape Mountain Dew (a soda) with approximately 90 ml left in the bottle. Neither was labeled with a name or open date. Also observed on the unit outside of room 312 D was a rolled up carpet approximately 2 feet long and approximately 18 inches high. The carpet was left unattended in the hall and no one was in room 312 D. During an interview with LPN 11 on 02/01/18 at 12:35 p.m., she indicated the Mountain Dew and 5 Hour Energy probably belonged to a resident and she did not know how a pill ended up on the floor. She indicated the carpet was left in the hall because "they" were working on room 312 D. At this time, the white tablet was identified as Tramadol (a pain reliever) 50 mg. 4. During a facility tour, with the DM (Director of Maintenance) in attendance, on 02/06/18 at 2:20 p.m., the exterior door opposite the main entry was observed to have a gap that permitted cold air to blow into the facility. No weatherstrip was observed on the door. During an interview, at that time, the DM indicated the door contracted in winter and expanded in the summer. This State Residential Finding relates to Complaint IN00241129.		practice. **Measures put into place /systemic changes made to ensure the alleged deficient practice does not reoccur.** Maintenance continues to inspect and repair areas of wallpaper and drywall that need to be repaired. Concerns forms are placed on every floor if there are areas that residents/visitors identify. These forms are reviewed daily. Maintenance to check all doors, to ensure there are no excessive gaps. Repairs made as necessary. Staff educated to look for foreign objects throughout the day, as there are multiple visitors and vendors touring the facility on a daily basis. Contractor that left carpet in hallway has been notified of deficient practice by employees, in writing, and agrees to not leave items in hallways, unattended.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are			

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	maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the dishwasher temperatures were maintained and the correct amount of sanitizer was used in the three compartment sink according to the manufacturer's guidelines and sanitizing of dishes and utensils. This deficient practice has the potential to affect 69 of 69 residents who eat from this kitchen. Findings include: 1. During an observation of the kitchen with the (FSD Food Service Director) on 01/29/2018 at 10:17 a.m., the dishwashing machine wash cycle reached 155 degrees Fahrenheit. During an interview at that time, the FSD indicated the wash cycle did not reach 160 degrees Fahrenheit to properly wash and sanitize the dishes and utensils. 2. During an observation of the 3 compartment sink, the FSD tested the sanitizer concentration of the third sink by immersing a QT-40 test strip into the water for 40 seconds and then compared the color to the packaging. The color of the strip indicated there was not any sanitizer in the water. The FSD indicated the concentration of the sanitizer should be at 200 to 400 ppm (parts per million). 3. During an observation of food temping with the FSD on 02/05/2018 at 5:03 p.m., the following was observed: one pan of catfish on the buffet line was noted to be 100 degrees Fahrenheit, at that time the FSD indicated the fish wasn't hot enough and removed the pan from the buffet line.	R 0273	Corrective actions accomplished for residents found to be affected by this alleged practice. Dishwasher was converted to chemical sanitation, until malfunction was identified and repaired. Three compartment sink was drained and was re-filled with the correct sanitizer solution. The item noted on the buffet table was removed. The chafing dish was re-lit, to ensure temperature of buffet line was proper temperature. The items on the salad bar found to not be at appropriate temperature were immediately removed. Ice was added to the salad bar to ensure proper temperature was sustained. Other residents having the potential to be affected by this alleged deficient practice All residents have potential to be affected by this alleged deficient practice. Measures put into place /systemic changes made to ensure the alleged deficient practice does not	03/12/2018

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	The left side of the salad bar under the salad dressings was noted to be 42 degrees Fahrenheit. The right side under the bean salad was noted to be 44 degrees Fahrenheit. The right side under the fruit cocktail was noted to be degrees Fahrenheit. During an interview at that time the FSD indicated the salad bar needed more ice to decrease the temperature. Section 3-501.16 of the FDA Food Code indicated, "...Except during preparation, cooking, or cooling ...time/temperature control for safety food shall be maintained at 135 degrees Fahrenheit or above ...or at 41 degrees Fahrenheit or below...." A current policy titled "...Dishwasher Operation, High Temperature Machine...." dated 9/2014, provided by the Executive Director on 1/29/18 at 1:50 p.m., indicated, "...Wash temperatures are to be...160 degrees for conveyor type machines...." A current undated policy titled "...Inservice-Three compartment Sink...." provided by the Executive Director on 1/29/2018 at 1:50 p.m., indicated, " ...Sanitizer in the third compartment insures that bacteria are destroyed...Third sink-sanitizing sink...Test sanitizer concentration...requires a concentration of 200-400 ppm to be effective...."		reoccur. Dietary staff educated by Food Services Director on proper temperature monitoring for dishwasher system. Dishwasher was found to have a loose connection, and was repaired. Dishwasher holds proper temperature. Dietary staff educated by Food Services Director on the proper procedure for the 3 compartment sink and sanitizer concentration. Dietary staff educated by Food Services Director to ensure all monitoring items are in place, to be used to test the solution. Dietary staff educated by Food Services Director on the proper food holding temperatures. How this corrective action will be monitored to ensure the alleged deficient practice will nor reoccur. For the Dishwasher system: Administrator/designee will perform random monitoring, 3 times per day, 5 days per week, for 4 weeks. Food Services Director/designee will continue to monitor, 3 times per day. For three compartment sink: Administrator/designee will perform random monitoring, 3 times per day, 5 days per week,	

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	155618	A. BUILDING 00 B. WING	02/07/2018

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			for 4 weeks. Food Services Director/designee will continue to monitor, 3 times per day. For food holding temperatures, Administrator/designee will perform random monitoring, 3 times per day, 5 days per week, for 4 weeks. Food Services Director/designee will continue to monitor, 3 times per day. Any deficiencies will be immediately corrected.	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review the facility failed to store medications for a resident who did not self administer medications for 1 of 1 residents observed for medication storage. (Resident 4) Finding includes: During an interview with Resident 4 on 02/07/18 at 10:40 a.m., he indicated he was currently storing 2 boxes of mediation in his closet and bottles of pills in his bathroom. He indicated he had informed the staff and requested they be removed. During an interview with the WD (Wellness Director) on 02/07/18 at 10:55 a.m., she indicated she was not aware of the medications in Resident 4's closet. A list of the medications removed from Resident	R 0295	**Corrective actions accomplished for residents found to be affected by this alleged practice.** Medications were removed from Resident #4 closet and bathroom. **Other residents having the potential to be affected by this alleged deficient practice** All assisted living residents have potential to be affected. **Measures put into place /systemic changes made to ensure the alleged deficient practice does not reoccur.** Residents, families, and nursing staff have been educated regarding storage of medications for residents	03/09/2018

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	4's closet and bathroom was provided by the WD on 02/07/18 at 1:43 p.m. The following medications were removed from the residents premises. One box containing 7 bottles of lactulose (a medication use to treat complication of liver disease) 10 gm (grams) /15 ml (milliliters). Each bottle contained 473 mls of medication. One box containing 7 bottle of lactulose 10 gm/15 ml. Each bottle contained 946 ml of medication. Four bottles of Torsemide (a diuretic) 20 mg (milligrams) Bottle one contained 590 tablets that expired on 11/24/16. Bottle two contained 533 tablets that expired on 11/24/16. Bottle three contained 178.5 tablets that expired on 12/31/16. Bottle four contained 393 tablets that expired on 06/29/16. A current policy provided by the ED (Executive Director) on 02/02/18 at 2:01 p.m., titled "...Delivery and Storage of Medication and Supplies...." indicated, "...Store medication and supplies in patient specific bins in the medication room...."		who do not self-administer medication. Future residents will be informed during the admission process to not store medications and to inform staff of medications. A letter to all residents and family members who are responsible parties were notified by letter. Notices also placed in common areas to ensure maximum dissemination of information. **How this corrective action will be monitored to ensure the alleged deficient practice will nor reoccur.** Wellness Direct/Designee will inform resident/families, when bringing in medications, of the medication storage policy for residents who do not self-administer medications. **What quality assurance program will be put into place?** Monitoring will continue and will be reviewed in monthly QA&A. Identified deficiencies will be corrected immediately and maintained as part of the QA&A process.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications			

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	in accordance with applicable laws of Indiana. Based on interview and record review the facility failed to provide mediation to a resident on two consecutive occasions for 1 of 1 resident observed for missed doses of medication. (Resident 4) Finding includes: Resident 4's record was reviewed on 01/29/18 at 2:30 p.m. Diagnoses included, but were not limited to, cirrhosis of the liver and muscle weakness. During an interview, with Resident 4 on 01/29/18 at 1:10 p.m. he indicated he had missed two doses of lactulose (a mediation used to treat complications of liver disease), on 01/08/18 at 4:00 p.m. and at 8:00 p.m. Resident 4 indicated he was informed the medication was not available in the facility. During an interview with LPN 12 on 01/29/18 at 3:45 p.m., she indicated when a medication was not available she checked the EDK (Emergency Drug Kit) first. A current EDK list of mediations, provided by the WD (Wellness Director) on 01/29/18 at 4:05 p.m., indicated Chronulac (the brand name for lactulose) 20 mg (milligrams)/30 ml (milligrams) was in the EDK. At that time, the WD indicated there were two EDKs in the facility, She was the nurse on duty that shift and did not have the medication in the EDK, on her unit. She was not aware that she could get the medication from the other EDK. A current policy, provided by the DON (Director of Nursing) on 01/30/18 at 4:37 p.m., titled, "...7.0	R 0297	**Corrective actions accomplished for resident found to be affected by this alleged practice** Nursing staff pulled missing medication from the skilled nursing emergency drug kit and resident received medication as ordered. It was identified that the Assisted Living EDK did not have this medication. Physician was notified when missing medication was identified. **Other residents having the potential to be affected by this alleged deficient practice** All Assisted Living Residents **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur.** The Quality Assurance Consultant provides education for Wellness Director and Wellness Director provides education for nursing staff. Wellness Director educated nursing staff regarding procedure for missed doses of medication and EDK utilization for Assisted Living. Additionally, Skilled Nursing Emergency Drug Kit utilization by Assisted Living residents during medication emergencies. **How this corrective action will be monitored to ensure the alleged**	03/09/2018

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	Medication Shortages/Unavailable Drugs...." indicated, "...if a medication shortage is discovered...A...nurse should obtain the ordered medication from the Emergency Drug Kit...."		**deficient practice will not recur.** Wellness Director /Designee will audit MAR three times a week x 4 weeks, twice a week x4 weeks, weekly x4 weeks and as needed thereafter. **What quality assurance program will be put into place?** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A to ensure substantial compliance	