STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN0021844 and IN00218471. Complaint IN00218444 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F226, and F282. Complaint IN00218471 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F226, and F282. Survey dates: January 4 & 5, 2017 Facility number: 000061 Provider number: 155136 AIM number: 1002886620 Census bed type: SNF/NF: 121 Total: 121 Census payor type: Medicare: 14 Medicaid: 85 Other: 22 Total: 121 Sample: 5	F 0000	This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey. Respectfully, Jerrell Harville, HFA, MSW, Executive Director.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 1/10/17.			
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).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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. (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 observation, record review, and interview, the facility to ensure the Physician was notified of a skin abrasion for 1 of 4 residents reviewed for wounds in a sample of 5. (Resident D) Finding includes: During Orientation Tour on 1/4/17 at 8:32 a.m., Resident D was observed in bed. Unit Manager #1 was present during the tour. The resident had a clear foam dressing in place to her right buttock area. The dressing was dated as last applied on 1/2/17. The Unit Manager	F 0157	Step One: The physician was notified for Resident D and appropriate treatment obtained. Step Two: All residents with current skin issues including abrasions were reviewed to ensure appropriate physician notification. No deficiencies were noted.	01/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	confirmed the dressing was dated 1/2/17. The record for Resident D was reviewed on 1/4/17 at 9:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, high blood pressure, and osteoarthritis. The 12/7/16 Minimum Data Set (MDS) quarterly assessment was reviewed. The resident's cognitive patterns for decision making were severely impaired. The resident was totally dependent on staff for bed mobility and transfers. The current Physician orders indicated there were no orders for the resident to have any treatments to the right buttock area. A Verification of Investigation report was completed on 1/2/17 at 12:05 p.m. The report indicated an abrasion was noted to the resident's right gluteal fold. The abrasion measured 1.0 cm x 1.0 cm x 0.1 cm (centimeter). The abrasion was noted after the resident was transferred with a lift device and was located in the area where the sling of the lift device made contact with the resident during use. When interviewed on 1/5/17 at 12:30 p.m., the Director of Nursing indicated		Step Three: Licensed Nurses will be re-educated on the Notification of Change in Resident Health Status Policy. The DNS and/or designee will randomly audit 5 residents medical records per unit weekly to ensure proper physician notification of change in resident health status. The DNS will report audit findings to the QAPI Committee monthly. Step Four: The results of the Physician Notification Audit will be reviewed in the Clinical Strat-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she spoke to the staff members involved with the transfer. The LPN informed her she had called the Physician at the time but did not receive a return call. No repeat phone calls were made to notify the Physician of the abrasion. Staff should have followed up with further calls to the Physician if no response was received from the first call. The facility policy title Notification of Change in Resident Health was reviewed on 1/4/17 at 2:00 p.m. The policy was last reviewed on 10/20/16. The policy indicated the Physician, Nurse Practitioner, or Physician Assistant were to be notified of the accident resulting in an abrasion. This Federal tag relates to Complaints IN00218444 and IN00218471. 3.1-5(a)(3)			
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.			
	Based on record review and interview the facility failed to ensure reference checks were completed and reviewed prior to allowing staff to work for 2 of 5 Employee files reviewed. (CNA #1 and CNA #2) Finding includes: The facility Employee Files were reviewed on 1/5/17 at 2:20 p.m. CNA's #1 and #2 were hired on 11/17/16. A "Skill Survey" report to check references for CNA #1 was initiated on 10/26/16. Three E-mail addresses	F 0226	Step One: CNA #1 is no longer employed at the facility. CNA #2 was identified and references were obtained. Step Two: Human resources completed an audit of current employees to ensure all reference checks were completed in accordance with facility policy. Step Three: HR personnel review an audit with Executive Director that no offers of employment would move forward without references responding in accordance with facility Policy. Step Four: The results of this audit be reviewed monthly by the QAPI Committee for six months. If after six months of review	01/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appeared on the report and noted the link for the reference person to click to complete the reference online had not been completed. The "Status" noted the references requested had not been addressed. A "Skill Survey" report to check references for CNA#2 was initiated on 10/12/16. Three E-mail addresses appeared on the report and noted the link for the reference person to click to complete the reference online had been completed for 1 of the 3 email addresses. The third reference listed did respond. The actual responses the one reference made were not listed, only verification that this reference had replied on 10/24/16. The other two references listed did not open the e-mail link to respond to the request. When interviewed on 1/4/17 at 2:30 p.m. the HR (Human Resources) Staff indicted when the newly hired Employees come in, they are asked to go online and have three references respond to an e-mail sent by the company. The program utilized by the facility did not allow the HR staff to send out references. With this system, no reference check results were sent to the facility until at least (2) of the (3) were completed. HR staff were not allowed to contact the references listed themselves.		without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	When interviewed on 1/4/17 at 3:00 p.m., the facility Administrator indicated he was unaware there were no results of the reference checks for the above CNA's. Corporate sends him the "clear" to hire, at which time he could begin the hiring process. He had to receive the clear from Corporate to start hiring any other staff. The Administrator indicated he had no knowledge of the above as he had the "clear" to hire from Corporate. The facility Administrator contacted a representative from the Agency providing the above service at this time. They informed the Administrator the business was not responsible to send reminders to the facility to recheck the reference or send out again. It was the responsibility of the facility to ensure the Employees had then completed. The Administrator had not been informed by the HR Director the results of the reference checks for the above Employees had not been completed. When interviewed again on 1/4/17 at 3:45 p.m., the HR Director indicated she had told these two CNA's they needed to follow through by either contacting the listed reference and instructing them to respond to the to link or provide other references and they did not. CNA #1 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reminded on 10/26/16 and 12/15/16. CNA #2 was reminded on 10/12/16, 10/13/16 and 10/14/16 with no results. The facility Administrator was present during the above interview with the HR Director. He confirmed the two CNA's had been working on the floor with residents and this should not have been allowed to work until the reference check concerns were completely addressed. The facility policy titled "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" was reviewed on 1/4/16 at 1:45 p.m. The policy was created on 11/14/16. Reference checks with the current and/or past employees were required. The Executive Director or Human Resources were to ensure that all screenings were accomplished. This Federal tag relates to Complaints IN00218444 and IN00218471. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure residents' plans of care were followed related to weekly skin inspections not completed as ordered or per the resident care plans for 2 of 4 residents with wounds in a sample of 5. (Residents D and E) Findings include: 1. The record for Resident D was reviewed on 1/4/17 at 9:13 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, high blood pressure, and osteoarthritis. The 12/7/16 Minimum Data Set (MDS) quarterly assessment was reviewed. The resident's cognitive patterns for decision making were severely impaired. The resident was totally dependent on staff	F 0282	Step One: Resident D was discharged from the facility on 1/5/2017. A skin review was completed for Resident E on 1/4/2017 with no new skin concerns were noted. Step Two: A skin review audit was completed for all current residents. Any deficiencies noted were corrected. Step Three: Licensed Nurses were re-educated on completion of the Weekly Skin Review Procedure. The DNS and/or designee will audit 5 random residents per unit weekly to ensure completion	01/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for bed mobility and transfers. The current Physician orders indicated there was an order written on 9/21/16 for staff to complete weekly skin assessments The 12/2016 Weekly Skin Review reports indicated reviews were completed on 12/7/16, 12/14/16, 12/21/16. No further reviews were completed in December 2016. The January 2017 Weekly Skin Reports indicated the first Weekly Skin Review report was completed on 1/4/2017 2. The record for Resident E was reviewed on 1/4/17 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, bipolar disorder, diabetes mellitus, high blood pressure, and anxiety disorder. The 11/10/16 Minimum Data Set admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15) and the resident's cognitive patterns were intact. A Care Plan initiated on 11/16/16 indicated the resident was at risk for Pressure Ulcers related to requiring assistance with bed mobility. Interventions included, but were not		of the Weekly Skin Review. The DNS will report audit findings to the QAPI Committee montly. Step Four: The results of the Weekly Skin Review Audit will be reviewed in the Clinical Strat-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly. .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, Staff to complete Weekly Skin inspections. Weekly Skin Review reports for December 2016 indicated no reports between 12/16/16 and 12/30/16 were completed. When interviewed on 1/4/17 at 2:25 p.m., the Director of Nursing indicated all residents were required to have Weekly skin inspections. This Federal tag relates to Complaints IN00218444 and IN00218471. 3.1-35(g)(2)			