STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

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F 0000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00254321. Complaint IN00254321-Substantiated. No deficiencies related to the allegation are cited. Survey dates: February 14, 15, 16, 19, 20, and 21, 2018 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Census Bed Type: SNF/NF: 130 SNF: 26 Total: 156 Census Payor Type: Medicare: 33 Medicaid: 88 Other: 35 Total: 156 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 23, 2018.	F 0000	**Plan of Correction for GREENWOOD MEADOWS** **F000 INITIAL COMMENTS** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

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

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	Based on interview and record review, the facility failed to ensure staff accurately coded a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for Activities of Daily Living (ADL) decline (Resident 87). Findings include: On 2/21/18 at 2:22 p.m., Resident 87's clinical record was reviewed. Diagnosis included, but were not limited to: dementia and hemiplegia (paralysis of one side of the body). A review of Resident 87's MDS assessment, dated 1/9/18, indicated, ".... transfer- how the resident moves between surfaces including to or from: bed, chair, wheelchair, standing position ... Activity did not occur- activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period ..." During an interview, on 2/21/18 at 2:44 p.m., the MDS coordinator indicated Resident 87 got out of bed and a review of the Certified Nursing Assistant's ADL documentation which indicated the resident was transferred out of the bed during the 7-day look back period. The transfer entry of, "activity did not occur," was a data entry error on the MDS and should have been coded as, "extensive assist." During an interview, on 2/21/2018 at 3:30 p.m., the Director of Nursing indicated the facility did not have a policy in regard to MDS coding. 3.1-31(d)	F 0641	**F 641 ACCURACY OF ASSESSMENTS** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** •□□□□□□□□ Resident #87 MDS assessment modified to reflect correct ADL functioning. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the alleged deficient practice. •□□□□□□□□ MDS/designee to review all residents in house to ensure all residents' ADL functioning are accurate by March 9, 2018. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** •□□□□□□□□ MDS/designee will conduct in-service with all-staff regarding accurate ADL coding by March 9, 2018. •□□□□□□□□ ED/designee will conduct in-service with department heads on ensuring accurate ADL coding is placed into MDS by	03/09/2018

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			March 9, 2018. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** •□□□□□□□□ The SSD/designee will monitor weekly using MDS Accuracy-Medicare-PPS QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date completion:** March 9, 2018	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest			

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	practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to implement care plan interventions for 2 of 2 residents at risk for falls (Residents 85 and 140) in a sample of 32 residents reviewed for care plans. Findings include: A.) On 2/14/18 at 10:15 A.M., Resident 85 was observed in his room, sitting in his wheelchair at the foot of his bed. The resident's call light button	F 0656	**F 656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**	03/09/2018

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	was clipped on the headboard of the resident's bed, out of his reach. The resident indicated he would use the call light button to call for assistance, but he did not know where it was. On 2/14/18 at 11:40 A.M., the resident was observed in his room, sitting in his wheelchair at the foot of his bed. The resident's call light button was clipped on the headboard of the resident's bed, out of his reach. The resident indicated he did not know where the call light button was. On 2/14/18 at 2:15 P.M., the resident was observed in his room, sitting in his wheelchair at the foot of his bed. The resident's call light button was clipped on the headboard of the resident's bed, out of his reach. On 2/19/18 at 9:15 A.M., the resident was observed in his room, sitting in his wheelchair at the foot of his bed. The resident's call light button was clipped on the headboard of the resident's bed, out of his reach. On 2/19/18 at 9:20 A.M., during an interview, the facility Administer indicated the resident's call light button was out of the reach of the resident and should not have been clipped to the headboard of the bed while the resident was seated at the foot of the bed. On 2/15/18 at 3:00 P.M., Resident 85's clinical record was reviewed. Diagnoses included, but not limited to, hemiplegia affecting right dominant side. The care plan, revised 2/19/18, indicated a problem with a start date of 5/24/16 as, "....resident is at risk for fall due to: impaired mobility, requires assistance with ADLs (activities of daily living)...". A goal with a target date of 4/9/18 indicated, "....resident fall risk factors will be		•□□□□□□□□ Resident #85 fall risk care plan updated and accurate. •□□□□□□□□ Resident #140 fall risk care plan updated and accurate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the alleged deficient practice. •□□□□□□□□ DNS/designee to review all residents in house to ensure fall care plans are updated and accurate for current interventions by March 9, 2018. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** •□□□□□□□□ DNS/designee will conduct in-service with IDT on ensuring care plan updates occur and are accurate including for fall interventions by March 9, 2018. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** •□□□□□□□□ The DNS/designee will monitor weekly using Care Plan Updating QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is	

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	reduced in an attempt to avoid significant fall related injury...". An approach with a start date of 5/24/16 indicated, "....call light in reach..." B.) On 2/14/18 at 10:20 A.M., Resident 140 was observed in his room, sitting in his wheelchair approximately 5 feet away from his bed. The resident's call light button was clipped to the resident's bed, out of his reach. The resident indicated he would use the call light button to call for assistance if he could reach it, but he could not reach it. On 2/14/18 at 11:30 A.M., the resident was observed in his room, sitting in his wheelchair approximately 5 feet away from his bed. The resident's call light button was clipped to the resident's bed, out of his reach. On 2/19/18 at 1:30 P.M., the resident was observed in his room, sitting in his wheelchair approximately 5 feet away from his bed. The resident's call light button was clipped to the resident's bed, out of his reach. On 2/19/18 at 1:35 P.M., during an interview, LPN 1 indicated the resident's call light button was out of the resident's reach should not have been clipped to the resident's bed while the resident was seated away from the bed. On 2/15/18 at 3:15 P.M., Resident 140's clinical record was reviewed. Diagnoses included, but not limited to, hemiplegia affecting right dominant side. The care plan, revised 2/2/18, indicated a problem with a start date of 1/4/16 as, "....resident is at risk for fall due to expresses fear of falling, history of falls, impaired mobility..." A goal with a target date of 4/24/18 indicated, "....resident fall risk factors will be reduced in an attempt to avoid		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date completion:** March 9, 2018	

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	significant fall related injury...". An approach with a start date of 1/4/16 indicated, "....call light in reach..." 3.1-35(a)			
F 0689 SS=G 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 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 provide supervision to maintain resident's safety while wandering which resulted in a fall with fracture that required medical intervention for 1 of 7 residents reviewed for accidents. (Resident 348) Findings include: On 2/16/18 at 2:56 p.m., Resident 348's clinical record was reviewed. Her admission date was 2/1/18. Diagnoses included, but were not limited to: displaced fracture of the right arm radius (one of the two bones in the arm), osteoporosis, vitamin D deficiency, and vascular dementia with behavioral disturbance. Resident 348's admission Minimum Data Set (MDS) assessment, dated 2/8/18, indicated she had severe cognitive impairment; wandered daily; wandering significantly intruded on the privacy or activities of others.	F 0689	**F 689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #348 care planned for intrusive wandering and falls with appropriate interventions placed. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents exhibiting	03/09/2018

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	A review of Resident 348's care plan, dated 2/1/18, indicated she had a risk for falls due to required assistance with activities of daily living (ADLs), weakness, hypertension (HTN), abnormalities of gait. The care plan indicated the following interventions: -Call light within reach -Environmental changes -Personal items in reach -Therapy screen -Non skid footwear when out of bed. Resident 348's care plan lacked documented interventions for assessed wandering and intrusive behaviors. At exit conference, on February 22, 2018 at 4:00 p.m., the facility did not provide documentation that indicated intrusive wandering careplan with interventions had been developed. A review of Resident 348's progress notes indicated the following: -On 2/4/18 at 12:59 a.m., she was agitated and aggressive all evening, wandered into other resident's rooms and beds. When asked by staff to leave the bed, she became aggressive, yelled, cursed and hit at the nurse. She walked the halls all evening and is now walking the halls at night, in and out of others' rooms, resting for a few minutes and back up. -On 2/4/18 at 4:51 a.m., she continued to roam the halls and into other residents' rooms, cursed at staff when asked to leave their room, stopped to rest for a few minutes. -On 2/7/18 at 1:08 a.m., she was found in another resident's room sitting on the floor. The current room resident indicated Resident 348 had attempted to sleep in the current resident's bed.		wandering have the potential to be affected by the alleged deficient practice. · DNS/designee to review all residents in house to ensure any resident exhibiting wandering, including intrusive wandering, will be accurately care planned with proper interventions by March 9, 2018. · DNS/designee to review all residents in house to ensure all fall interventions are accurate and on care plan by March 9, 2018. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · ED/designee will conduct in-service with IDT on care plan updating by March 9, 2018. · DNS/designee will conduct in-service with all staff regarding intrusive wandering interventions by March 9, 2018. · DNS/designee will conduct in-service with all staff regarding fall management policy by March 9, 2018. DNS/designee will make rounds during all shifts Monday-Friday and weekend supervisor/designee on Saturday and Sunday to ensure that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent	

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	Resident 348 became combative (scratched and kicked) towards staff and the other resident. Numerous attempts to try and redirect Resident 348 was ineffective. Resident 348's right wrist was swollen and painful to touch. Medical Doctor (MD) was notified and ordered an X-ray of the right wrist. -On 2/7/18 at 2:37 a.m., She attempted to walk back towards her room and began to lose her balance. Staff lowered her to the ground to prevent injury. -On 2/7/18 at 12:58 p.m., a behavior note, dated for 2/7/18 at 1:08 a.m., indicated she was found wandering into another resident's room. She tried to get into another resident's bed. Other resident asked her to leave and then she scratched the other resident. She was new to the facility and was having some difficulty adjusting. She does not know where her room was located at that time. The facility will also clearly mark her room with her name in bold letters. -On 2/8/18 at 8:18 a.m., an Interdisciplinary Team (IDT) skin note indicated she had a new bruise noted to the right wrist. The root cause was from a recent fall with fracture to the right wrist. She preferred to wander freely in unit and goes in and out of other residents' rooms even with re-direction. She refused to comply with staff assistance. -On 2/7/18 at 4:06 p.m., an IDT fall note indicated IDT team reviewed the fall that occurred on 2/7/18 at 2:30 a.m. She attempted to walk herself back to her room and and she lost her balance. The staff was able to intervene and lower her to the floor. She was involved in a resident to resident altercation one hour previous to this fall in which she fell and landed on her wrist. An X-ray showed a fracture to the right wrist. The IDT attributed this fall to increased weakness related to pain from the fracture and increased tiredness from the physical altercation. An orthopedic		accidents and intrusive wandering using the Nurse Manager Rounds Tool. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DNS/designee will monitor weekly using Care Plan Updating QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. · The DNS/designee will monitor weekly using Fall Program QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. · The DNS/designee will monitor weekly using Accommodation of Needs QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then	

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	(musculoskeletal doctor) consult had been scheduled for her. She was being treated for pain and was placed on 15 minute checks. -On 2/11/18 at 1:43 a.m., she wandered the halls and into other residents' rooms. She was redirected at least seven times this shift. She closed doors loudly and often woke residents. -On 2/11/18 at 2:13 p.m., she intrusively wandered from room to room and attempted to lay in occupied beds. The cast to right wrist was present and was currently clean dry and intact. -On 2/13/18 at 3:23 a.m., she continued to be intrusive in multiple residents' rooms. When redirected she slammed the doors to those rooms purposefully hard and was agitated. She was redirected back to her room through the night and laid in her bed, but was up shortly after roaming and going into other rooms that were not hers. -On 2/14/18 at 9:43 a.m., she wandered through the halls and into other's rooms daily. On 02/16/18 at 10:22 a.m., Resident 348 was observed sitting in a chair, beside the bed, in the room of Resident 86. Not Resident 348's room. Staff were observed to not provide supervision or redirection to Resident 348. Continued review of progress note indicated: -On 2/18/18 at 12:08 a.m., she wandered about, in and out of other residents' rooms. She became angry when redirected to her own room, slammed doors and argued with staff. -On 2/19/18 at 12:29 a.m., she became agitated during routine care. She spit, hit, pinched, and cursed at staff. She wandered the halls, in and out of every room but her own. She was upsetting some of the residents. She was redirected to her room several times, but refused to stay there. -On 2/19/18 at 5:14 a.m., She continued to roam the halls and into other residents' rooms. Several		quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed **5. Date completion:** March 9, 2018	

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	times she woke and upset them. When staff attempted to redirect, she cursed and scratched the nurse. On 02/20/18 at 09:56 a.m., Resident 348 was observed resting with their eyes shut in a bed in the room of Resident 26. Not Resident 348's room. Staff were observed to not provide supervision or redirection to Resident 348. On 02/20/18 at 12:12 p.m., Resident 348 was observed sitting in dining room (DR) with a blue cast on their right arm eating lunch. During an interview, on 02/20/18 at 11:42 a.m., Qualified Medication Aide (QMA) 1 indicated Resident 348 roamed all day and night and got upset with staff when they try to redirect her from going into other residents' rooms, although residents get frustrated when she wanders in their room. Resident 348 had a bright orange sign with her name on the door, and staff will direct her to room after meals. Resident 348 went into Resident 124's room and tried to get into her bed, which made Resident 124 upset and Resident 348 was found laying on her right arm (incident dated 2/7/18 at 1:08 a.m.). QMA 1 did not indicate how the facility provided supervision to ensure Resident 348's safety from intrusive wandering. On 02/20/18 at 11:58 a.m., the Memory Care Program Coordinator indicated Resident 348 wandered into other residents' rooms and the other residents got frustrated by her wandering. She did not indicate how the facility provided supervision to ensure Resident 348's safety from intrusive wandering. On 02/21/18 at 02:19 p.m., the Director of Nursing (DON) indicated staff was aware of Resident 348			

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	155788	A. BUILDING 00 B. WING	02/21/2018

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GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

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	going in and out of other residents' rooms and if staff can't find the resident they start looking in other residents' rooms for her. The staff on memory care unit provide supervision, activities, and keeping the same staff scheduled. On 2/21/18 at 3:35 p.m., the DON provided the policy, "Fall Management Program," dated November, 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls..." 3.1-45(a)(2)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			

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	§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure staff identified and reported a skin abrasion for 1 of 32 residents reviewed for skin conditions. (Resident 250) Findings include: Interview, on 2/15/2018 at 3:32 p.m., Resident 250 was observed to have an undressed nickel sized abrasion on the left inside forearm. The resident indicated she could not recall how she sustained the abrasion. Interview, on 2/15/2018 at 3:35 p.m., a family member for Resident 250 indicated she did not know how the resident got the abrasion, but she was concerned and thought the physician needed to look at it. Resident 250's clinical record was reviewed on 2/18/2011 at 11:21 a.m. Diagnoses included, but were not limited to, muscle weakness and personal history of urinary tract infection. Resident 250 was admitted on 2/13/2018. The Admission Minimum Data Set (MDS) was observed to be still in process. The Brief Interview	F 0726	**F 726 COMPETENT NURSING STAFF** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** •□□□□□□□□ Resident #250 has had full body assessment completed with appropriate skin documentation, notification, and treatment in place. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the alleged deficient practice. •□□□□□□□□ DNS/designee to conduct house wide skin sweep to determine all skin impairment issues identified with appropriate	03/09/2018

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	for Mental Status (BIMS) total score had not been calculated. A review of the current care plans for Resident 250 indicated there were no care plans or interventions in place for the skin abrasion to the resident's left inside forearm. On 2/20/2018 at 12:18 p.m., a Weekly Nursing Summary and Skin Assessment was performed on Resident 250. The report indicated, "... Indicate any areas of skin integrity alteration the resident currently has ... check all that apply ... None of the above ..." A review of Resident 250's shower sheets from 2/14/2018 and 2/17/2018, lacked documentation of resident having an abrasion to the left inside forearm. On 2/21/2018 at 11:54 a.m., Resident 250 was observed to have the same undressed nickel sized abrasion on the left inside forearm. The abrasion was surrounded by several red colored bruised areas. The resident could not recall ever having a dressing put on the area. On 2/21/2018 at 11:56 a.m., the Unit Manager (UM 1) for the 400 hall indicated he did not know Resident 250 had an abrasion on the left inside forearm and didn't believe it was there on 2/20/2018. On 2/21/2018 at 2:30 p.m., the Director of Nursing (DON) did not deny the wound had not been assessed or reported in Resident 250's clinical record. On 2/21/2018 at 4:00 p.m., the DON provided the facility's policy, "Skin Management Program" with		documentation inputted per policy by March 9, 2018. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** •□□□□□□□□ DNS/designee will conduct in-service with all nursing staff regarding skin management program policy by March 9, 2018. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** •□□□□□□□□ The DNS/designee will monitor weekly using Wounds and Skin Prevention QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date completion:** March 9, 2018	

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	the most current date of 11/2017, and indicated it was the policy currently being used by the facility. The policy indicated, " ... 5. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. a). The licensed nurse is responsible for assessing any and all skin alterations by the direct caregivers on the shift reported ... Procedure For Alterations In Skin Integrity-Pressure and Non-Pressure ... 3. All alterations in skin integrity will be documented in the medical record ..."			
F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure staff maintained kitchen equipment in a safe and working manner for 1 of 1 kitchen observed. Findings include: During an initial kitchen tour, on 2/14/18 at 11:00 a.m., with the Dietary Manager present two back burners on the stove were observed to not ignite. The Dietary Manager indicated she did not know how long the burners were out since staff did not use those burners, however, she would tell the maintenance supervisor. No work orders were provided to the survey team by facility staff before the survey exit conference, on 2/22/18 at 4:00 p.m.	F 0908	**F 908 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** •□□□□□□□□ No residents affected by the alleged deficient practice **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** •□□□□□□□□ No other residents	03/09/2018

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	On 2/21/18 at 3:37 p.m., the Director of Nursing provided the facility policy, "Kitchen Safety Guidelines," revised July, 2017, and indicated it was the policy currently being used. The policy indicated, "....1. All employees will report defective equipment ... or safety hazards to the supervisor ..." 3.1-19(bb)		affected by the alleged deficient practice. •□□□□□□□□ Maintenance Supervisor has had burners on stove repaired. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** •□□□□□□□□ ED/designee will conduct in-service with dietary staff regarding functioning equipment and reporting by March 9, 2018. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** •□□□□□□□□ The Maintenance Supervisor/designee will monitor weekly using Environment QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5. Date completion:** March 9, 2018	