STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 8, 9, 10, 13, 14, 15, 16, 17, 20, and 21, 2015. Facility number: 000103 Provider number: 155196 AIM number: 100290000 Census bed type: SNF: 33 SNF/NF: 48 Residential: 71 Total: 152 Census Payor Type: Medicare: 31 Medicaid: 35 Other: 15 Total: 81 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 0224 SS=E Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure strategies were implemented to prevent staff to resident mistreatment for 9 of 9 residents reviewed for an allegation of mistreatment. (Resident #107, #29, #96, #17, #62, #44, #89, #86, and an anonymous resident) Findings include: 1.) A review on 07/9/2015 at 10 A.M., of an incident report dated 03/31/2015, indicated Resident #107 reported 2 staff members yelled and treated her rudely. The incident follow up report dated 04/06/2015, indicated both employees were cleared and brought back to work upon completion of the investigation. A Minimal Data Set (MDS) assessment dated 03/04/2015, assessed Resident #107 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 2.) A review on 07/9/2015 at 10 A.M., of an incident report dated 04/07/2015, indicated Resident #29 reported a Certified Nursing Assistant (CNA) raised	F 0224	F224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MIS APPROPRIATION **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents #107, #29, #96, #17, #62, #44, #89, and #86 have been assessed by social services and monitored to ensure no negative outcomes have occurred and to date, no negative outcomes have been discovered by the assessments conducted. The anonymous resident that voiced concerns has had no negative outcomes either based on the additional actions the facility took by interviewing 100% of the remaining residents using the QIS abuse questionnaire. The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** A thorough investigation was conducted on every employee (CNA #6 and all others) acused of mistreatment and the administrative staff at the facility in conjunction with corporate	08/14/2015

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	their voice at her. The follow up report dated 04/10/2015, indicated the CNA was reinstated to work. A Minimal Data Set (MDS) assessment dated 03/12/2015, assessed Resident #29 as having a Brief Interview for Mental Status (BIMs) score of 9 out of 15, indicating the resident was able to be interviewed. 3.a.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/07/2015, indicated a family member reported a Certified Nursing Assistant (CNA) was extremely rude to Resident #96. The follow up report dated 06/17/2015, indicated the employee was terminated on 06/17/2015, for sub-standard work. b. A review on 07/9/2015 at 10 A.M., of an incident report dated 07/08/2015, indicated Resident #96 reported CNA #6 was mean. A Minimal Data Set (MDS) assessment dated 05/06/2015, assessed Resident #96 as having a Brief Interview for Mental Status (BIMs) score of 7 out of 15, moderate cognitive impairment. During an interview on 07/09/2015 at 4:30 P.M., the Director of Nursing (DON) indicated the DON office relocated during the month of April 2015, to resident care areas to better monitor staff to resident interactions.		oversight have taken appropriate actions on each employee including: further education, progressive discipline, and terminiation. All residents, family members and staff have the potential to be affected by the deficient practice. All staff members will be in-serviced on all types of abuse to include every type of allegation and complaint issue dating back to 4 to 5 months ago to current. The inservicing will begin immediately and all shifts will receive the training prior to working in the building until 100% compliance is achieved. Third party vendors will receive the same training. A post test will be given with 10 specific issues surrounding the exact issues trended for the reportables dating back 4 to 5 months to current and staff will be required to achieve a 100% or higher score to demonstrate competency. An action plan was created for a specific reportable from June 20, 2015 by the director of nursing at the same time June 20, 2015 to address the exact abuse reportable issues that were reported at that time. Changes were introduced into the community to include: (1) weekend designated supervisor solely responsible to manage and prevent customer care concerns and report directly to the director of nursing. Staff patterns were changed, decrease in hours of staff to prevent burnout and hiring	

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	4.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/20/2015, indicated a family member reported a Certified Nursing Assistant (CNA) called Resident #17 a derogatory term and was rude and intimidating to Resident #17. 5.) A review on 07/9/2015 at 10 A.M., of an incident report dated 07/05/2015, indicated Resident # 62 reported a Certified Nursing Assistant (CNA) hit her head on the siderail when changing her. Resident #62 stated she told the CNA to stop, but the CNA continued. The follow up report dated 07/10/2015, indicated the allegation was unsubstantiated and the CNA returned to work with no disciplinary action. A Minimal Data Set (MDS) assessment dated 05/07/2015, assessed Resident #62 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 6.) During a stage 1 interview on 07/08/2015, an anonymous resident reported an unknown night shift staff member told Resident #44, "I've already been in here several times. You will have to wait for care." A Minimal Data Set (MDS) assessment dated 06/06/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs)		fair to cover shifts to prevent staff burn out. The new nurse manager that is covering weekends will begin using CQR audit tools to conduct staff, family, and resident interviews, 10 will be done on random people (staff, residents and families) each Saturday and Sunday and the results will be kept by the administrator and reviewed weekly for 8 weeks by the corporate nurse consultant and monthly after that for 3 months and reevaluated by the director of operations. All residents and family members have been interviewed by social service(s) designee from outside source utilizing the QIS family interview questionnaire on July 10, 2015. Any findings will be reported to the administrator immediately and then the ISDH with a thorough f/u investigation. The facility has retained a third party social services consultant firm to visit once per month for 3 months to conduct randome resident, staff and family abuse interviews using the QIS questionnaire to ensure the facility has a system in place that prevents staff to resident mistreatment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over	

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	score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/08/2015 at 4:30 P.M., the Administrator indicated having no knowledge of this incident. 7.) During a stage 1 interview on 07/08/2015, an anonymous resident reported overhearing an unknown employee tell another resident, "I've been in here 5 times, what the h--- do you want?" A Minimal Data Set (MDS) assessment dated 06/06/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/08/2015 at 4:30 P.M., the Administrator indicated having no knowledge of this incident. 8.) During a stage 1 interview on 07/09/2015, Resident #89 indicated an evening shift staff member jumped all over her for not going to dialysis. A Minimal Data Set (MDS) assessment dated 06/07/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed.		each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. A new CQR tool will be developed to review the results on the interviews to determine if any trends exists such as: shift, days of the week, employee type or specific halls. Action plans will be created to address any trends or findings and reported through the QA committee and monitored monthly by the corporate nurse and director of operations monthly for 3 months and re-evaluated after that. Staff training tools will be introduced and inserviced monthly for the next 3 months related specifically to abuse and customer service with competency testing conducted and a threshold of 90% will be mandatory on all posttests to ensure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention. Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additional interventions, actions and oversight to ensure compliance. The corporate nurse consultant will conduct weekly inspections of	

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	During an interview on 07/09/2015 at 12:55 P.M., the Administrator indicated having no knowledge of this incident. 9.) During a stage 1 interview on 07/09/2015 at 4:22 P.M., Resident #86 indicated a night shift Certified Nursing Assistant (CNA) talked with an attitude and stated this resident was not the only resident that needed to be taken care of. A Minimal Data Set (MDS) assessment dated 06/10/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 13 out of 15, indicating the resident was able to be interviewed. During an interview on 07/09/2015 at 5:00 P.M., the Administrator indicated having no knowledge of this incident. During an interview on 07/9/2015 at 4:30 P.M., the DON indicated some of the reportables were considered poor customer service rather than abuse. The Administrator indicated some residents misperceive staff member's communication at times. During an interview on 07/10/2015 at 11:03 A.M., regarding a pro-active intervention to monitor for and prevent staff to resident mistreatment, the Administrator indicated the pro-active		this action plan for compliance using a CQR audit tool to ensure all pieces are performed exactly to the letter of this plan. This will be done weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services and the nurse consultant will re-evaluate the oversight after that. As the QA committee meets monthly abuse reportable events will be reviewed to determine any trends in shifts or days of the week or other types of trends. If a trend is identified the QA committee will put a plan in place to address that specific cohort of staff/shift/day of the week to ensure mistreatment is dissiminated. A third party social services consultant Lacy Beyl and Associates will conduct 3 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic change then Lacy Beyl services will be continued until the culture of abuse prevention is integrated into the community. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	

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	intervention in place was the Caring Hearts Program (a resident communication program that allows them to voice grievances). No other specific pro-active interventions were indicated to be in place prior to June 2015. During an interview on 07/10/2015 at 12:31 P.M. regarding how the night shift staff is monitored, the Regional Director of Operations indicated, "Night shift staff issues were not brought to our attention prior to this survey." On 07/14/2015 at 10:56 A.M., the Clinical Nurse Consultant provided a facility policy, titled, "Abuse Prevention," dated 08/21/2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "...Our abuse prevention/intervention program includes, but is not necessarily limited to....d. Informing residents and family members upon the resident's admission to the facility how and to whom complaints, grievances, and incidents of abuse should be reported.... i. Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their		**i.e., what quality assurance program will be put into place?** The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. Staff training tools will be introduced and inserviced monthly for the next 3 months related specifically to abuse and customer service with competency testing conducted and a threshold of 90% will be mandatory on all post tests to ensure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention. Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additional interventions, actions and oversight to ensure compliance. The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool. This will be done weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services or the nurse consultant	

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	clothing/beds, etc.)..." 3.1-28(a)		will re-evaluate the oversight after that. A third party social services consultant Lacy Beyl and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic change then Lacy Beyl services will be continued until the culture of abuse prevention is integrated into the community. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	
F 0225 SS=E Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a			

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	court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 ensure a corrective action had been implemented as indicated by facility policy to prevent staff to resident mistreatment for 9 of 9 residents reviewed for an allegation of	F 0225	F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4)INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS **What Corrective action(s) will be accomplished for those residents**	08/14/2015

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	mistreatment. (Resident #107, #29, #96, #17, #62, #44, #89, #86, and an anonymous resident) Findings include: 1.) A review on 07/9/2015 at 10 A.M., of an incident report dated 03/31/2015, indicated Resident #107 reported 2 staff members yelled and treated her rudely. The incident follow up report dated 04/06/2015, indicated both employees were cleared and brought back to work upon completion of the investigation. A Minimal Data Set (MDS) assessment dated 03/04/2015, assessed Resident #107 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 2.) A review on 07/9/2015 at 10 A.M., of an incident report dated 04/07/2015, indicated Resident #29 reported a Certified Nursing Assistant (CNA) raised their voice at her. The follow up report dated 04/10/2015, indicated the CNA was reinstated to work. A Minimal Data Set (MDS) assessment dated 03/12/2015, assessed Resident #29 as having a Brief Interview for Mental Status (BIMs) score of 9 out of 15, indicating the resident was able to be interviewed.		**found to have been affected by the d eficient practice?** Residents #107, #29, #96, #17, #62, #44, #89, and #86 have been assessed by social services and monitored to ensure no negative outcomes have occurred and to date, no negative outcomes have been discovered by the assessments conducted. The anonymous resident that voiced concerns has had no negative outcomes either based on the additional actions the facility took by interviewing 100% of the remaining residents using the QIS abuse questionnaire. The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment. Each report will be taken serious, the harmful situation will be removed immediately and then reported to the ISDH. Abuse investigation will be conducted thoroughly to help facility determine corrective actions for each case. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, family members and	

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	3.a.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/07/2015, indicated a family member reported a Certified Nursing Assistant (CNA) was extremely rude to Resident #96. The follow up report dated 06/17/2015, indicated the employee was terminated on 06/17/2015, for sub-standard work. b. A review on 07/9/2015 at 10 A.M., of an incident report dated 07/08/2015, indicated Resident #96 reported CNA #6 was mean. A Minimal Data Set (MDS) assessment dated 05/06/2015, assessed Resident #96 as having a Brief Interview for Mental Status (BIMs) score of 7 out of 15, moderate cognitive impairment. During an interview on 07/09/2015 at 4:30 P.M., the Director of Nursing (DON) indicated the DON office relocated during the month of April 2015, to resident care areas to better monitor staff to resident interactions. 4.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/20/2015, indicated a family member reported a Certified Nursing Assistant (CNA) called Resident #17 a derogatory term and was rude and intimidating to Resident #17. 5.) A review on 07/9/2015 at 10 A.M., of an incident report dated 07/05/2015,		staff have the potential to be affected by the deficient practice. All staff members will be inserviced on all types of abuse to include every type of allegation and complaint issue dating back to 4 to 5 months ago to current. The inservicing will begin immediately and all shifts will receive the training prior to working in the building until 100% compliance is achieved. Third party vendors will receive the same training. A post test will be given with 10 specific issues surrounding the exact issues trended for the reportables dating back 4 to 5 months to current and staff will be required to achieve a 100% score to demonstrate competency. An action plan was created for a specific reportable from June 20, 2015 by the director of nursing at the same time June 20, 2015 to address the exact abuse reportable issues that were reported at that time. Changes were introduced into the community to include: (1) weekend designated supervisor solely responsible to manage and prevent customer care concerns and report directly to the director of nursing. Staff patterns were changed, decrease in hours of staff to prevent burnout and hiring fair to cover shifts to prevent staff burn out. The new nurse manager that is	

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	indicated Resident # 62 reported a Certified Nursing Assistant (CNA) hit her head on the siderail when changing her. Resident #62 stated she told the CNA to stop, but the CNA continued. The follow up report dated 07/10/2015, indicated the allegation was unsubstantiated and the CNA returned to work with no disciplinary action. A Minimal Data Set (MDS) assessment dated 05/07/2015, assessed Resident #62 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 6.) During a stage 1 interview on 07/08/2015, an anonymous resident reported an unknown night shift staff member told Resident #44, "I've already been in here several times. You will have to wait for care." A Minimal Data Set (MDS) assessment dated 06/06/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/08/2015 at 4:30 P.M., the Administrator indicated having no knowledge of this incident. 7.) During a stage 1 interview on 07/08/2015, an anonymous resident		covering weekends will begin using CQR audit tools to conduct staff, family, and resident interviews, 10 will be done on random people (staff, residents and families) each Saturday and Sunday and the results will be kept by the administrator and reviewed weekly for 8 weeks by the corporate nurse consultant and monthly after that for 3 months and reevaluated by the director of operations. All residents and family members will be interviewed by social service(s) designee from outside source utilizing the QIS family interview questionnaire on July 10, 2015. Any findings will be reported to the administrator immediately and then the ISDH with a thorough f/u investigation. The facility has retained a third party social services consultant firm to visit once per month for 3 months to conduct randome resident, staff and family abuse interviews using the QIS questionnaire to ensure the facility has a system in place that prevents staff to resident mistreatment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	155196	A. BUILDING 00 B. WING	07/21/2015

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	reported overhearing an unknown employee tell another resident, "I've been in here 5 times, what the h--- do you want?" A Minimal Data Set (MDS) assessment dated 06/06/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/08/2015 at 4:30 P.M., the Administrator indicated having no knowledge of this incident. 8.) During a stage 1 interview on 07/09/2015, Resident #89 indicated an evening shift staff member jumped all over her for not going to dialysis. A Minimal Data Set (MDS) assessment dated 06/07/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/09/2015 at 12:55 P.M., the Administrator indicated having no knowledge of this incident. 9.) During a stage 1 interview on 07/09/2015 at 4:22 P.M., Resident #86 indicated a night shift Certified Nursing Assistant (CNA) talked with an attitude and stated this resident was not the only		A thorough investigation was conducted on every employee (CNA #6 and all others) acused of mistreatment and the administrative staff at the facility in conjunction with corporate oversight have taken appropriate actions on each employee including: further education, progressive discipline, and terminiation. The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. A new CQR tool will be developed to review the results on the interviews to determine if any trends exists such as: shift, days of the week, employee type or specific halls. Action plans will be created to address any trends or findings and reported through the QA committee and monitored monthly by the corporate nurse and director of operations monthly for 3 months and re-evaluated after that. Staff training tools will be introduced and inserviced monthly for the next 3 months related specifically to abuse and customer service with competency testing conducted and a threshold of 90%	

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	resident that needed to be taken care of. A Minimal Data Set (MDS) assessment dated 06/10/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 13 out of 15, indicating the resident was able to be interviewed. During an interview on 07/09/2015 at 5:00 P.M., the Administrator indicated having no knowledge of this incident. During an interview on 07/9/2015 at 4:30 P.M., the DON indicated some of the reportables were considered poor customer service rather than abuse. The Administrator indicated some residents misperceive staff member's communication at times. During an interview on 07/10/2015 at 11:03 A.M., regarding a pro-active intervention to monitor for and prevent staff to resident mistreatment, the Administrator indicated the pro-active intervention in place was the Caring Hearts Program (a resident communication program that allows them to voice grievances). No other specific pro-active interventions were indicated to be in place prior to June 2015. During an interview on 07/10/2015 at 12:31 P.M. regarding how the night shift		will be mandatory on all posttests to ensure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention. Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additional interventions, actions and oversight to ensure compliance. The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool. This will be done weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services or nurse consultant will re-evaluate the oversight after that. A third party social services consultant Lacy Beyl and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic	

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	staff is monitored, the Regional Director of Operations indicated, "Night shift staff issues were not brought to our attention prior to this survey." On 07/14/2015 at 10:56 A.M., the Clinical Nurse Consultant provided a facility policy, titled, "Abuse Prevention," dated 08/21/2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "...Our abuse prevention/intervention program includes, but is not necessarily limited to....d. Informing residents and family members upon the resident's admission to the facility how and to whom complaints, grievances, and incidents of abuse should be reported.... i. Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their clothing/beds, etc.)..." 3.1-28(a)		change then Lacy Beyl services will be continued until the culture of abuse prevention is integrated into the community. As the QA committee meets monthly abuse reportable events will be reviewed to determine any trends in shifts or days of the week or other types of trends. If a trend is identified the QA committee will put a plan in place to address that specific cohort of staff/shift/day of the week to ensure mistreatment is dissiminated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. Staff training tools will be introduced and inserviced monthly for the next 3 months related specifically to abuse and customer service with competency testing conducted and a threshold of 90% will be mandatory on all post tests	

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			to ensure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention. Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additional interventions, actions and oversight to ensure compliance. The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool. This will be done weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services or the nurse consultant will re-evaluate the oversight after that. A third party social services consultant Lacy Beyl and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic change then Lacy Beyl services will	

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			be continued until the culture of abuse prevention is integrated into the community. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	
F 0226 SS=E Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of their written policy and procedures that resident mistreatment for 9 of 9 residents reviewed for an allegation of	F 0226	F226 483.13(c) DEVELOPMENT/IM[LEMENT ABUSE/NEGLECT, ETC POLICIES **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	08/14/2015

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	mistreatment. (Resident #107, #29, #96, #17, #62, #44, #89, #86, and an anonymous resident) Findings include: 1.) A review on 07/9/2015 at 10 A.M., of an incident report dated 03/31/2015, indicated Resident #107 reported 2 staff members yelled and treated her rudely. The incident follow up report dated 04/06/2015, indicated both employees were cleared and brought back to work upon completion of the investigation. A Minimal Data Set (MDS) assessment dated 03/04/2015, assessed Resident #107 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 2.) A review on 07/9/2015 at 10 A.M., of an incident report dated 04/07/2015, indicated Resident #29 reported a Certified Nursing Assistant (CNA) raised their voice at her. The follow up report dated 04/10/2015, indicated the CNA was reinstated to work. A Minimal Data Set (MDS) assessment dated 03/12/2015, assessed Resident #29 as having a Brief Interview for Mental Status (BIMs) score of 9 out of 15, indicating the resident was able to be interviewed.		Residents #107, #29, #96, #17, #62, #44, #89, and #86 have been assessed by social services and monitored to ensure no negative outcomes have occurred and to date, no negative outcomes have been discovered by the assessments conducted. The anonymous resident that voiced concerns has had no negative outcomes either based on the additional actions the facility took by interviewing 100% of the remaining residents using the QIS abuse questionnaire. The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment. The facility has fully implemented the company policy and procedure related to resident mistreatment, abuse, abuse prevention, neglect and misallocation. Each report will be taken serious, the harmful situation will be removed immediately and then reported to the ISDH. Abuse investigation will be conducted thoroughly to help facility determine corrective actions for each case. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents, family members and staff have the potential to be affected by the deficient practice. All staff members will be inserviced	

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	3.a.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/07/2015, indicated a family member reported a Certified Nursing Assistant (CNA) was extremely rude to Resident #96. The follow up report dated 06/17/2015, indicated the employee was terminated on 06/17/2015, for sub-standard work. b. A review on 07/9/2015 at 10 A.M., of an incident report dated 07/08/2015, indicated Resident #96 reported CNA #6 was mean. A Minimal Data Set (MDS) assessment dated 05/06/2015, assessed Resident #96 as having a Brief Interview for Mental Status (BIMs) score of 7 out of 15, moderate cognitive impairment. During an interview on 07/09/2015 at 4:30 P.M., the Director of Nursing (DON) indicated the DON office relocated during the month of April 2015, to resident care areas to better monitor staff to resident interactions. 4.) A review on 07/9/2015 at 10 A.M., of an incident report dated 06/20/2015, indicated a family member reported a Certified Nursing Assistant (CNA) called Resident #17 a derogatory term and was rude and intimidating to Resident #17. 5.) A review on 07/9/2015 at 10 A.M., of an incident report dated 07/05/2015,		on all types of abuse to include every type of allegation and complaint issue dating back to 4 to 5 months ago to current. The inservicing will begin immediately and all shifts will receive the training prior to working in the building until 100% compliance is achieved. Third party vendors will receive the same training. A post test will be given with 10 specific issues surrounding the exact issues trended for the reportables dating back 4 to 5 months to current and staff will be required to achieve a 100% score to demonstrate competency. An action plan was created for a specific reportable from June 20, 2015 by the director of nursing at the same time June 20, 2015 to address the exact abuse reportable issues that were reported at that time. Changes were introduced into the community to include: (1) weekend designated supervisor solely responsible to manage and prevent customer care concerns and report directly to the director of nursing. Staff patterns were changed, decrease in hours of staff to prevent burnout and hiring fair to cover shifts to prevent staff burn out. The new nurse manager that is covering weekends will begin using CQR audit tools to conduct staff, family, and resident interviews, 10 will be done on random people (staff, residents and families) each Saturday and Sunday and the results	

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	indicated Resident # 62 reported a Certified Nursing Assistant (CNA) hit her head on the siderail when changing her. Resident #62 stated she told the CNA to stop, but the CNA continued. The follow up report dated 07/10/2015, indicated the allegation was unsubstantiated and the CNA returned to work with no disciplinary action. A Minimal Data Set (MDS) assessment dated 05/07/2015, assessed Resident #62 as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. 6.) During a stage 1 interview on 07/08/2015, an anonymous resident reported an unknown night shift staff member told Resident #44, "I've already been in here several times. You will have to wait for care." A Minimal Data Set (MDS) assessment dated 06/06/2015, assessed anonymous resident as having a Brief Interview for Mental Status (BIMs) score of 15 out of 15, indicating the resident was able to be interviewed. During an interview on 07/08/2015 at 4:30 P.M., the Administrator indicated having no knowledge of this incident. 7.) During a stage 1 interview on 07/08/2015, an anonymous resident		will be kept by the administrator and reviewed weekly for 8 weeks by the corporate nurse consultant and monthly after that for 3 months and reevaluated by the director of operations. All residents and family members will be interviewed by social service(s) designee from outside source utilizing the QIS family interview questionnaire on July 10, 2015. Any findings will be reported to the administrator immediately and then the ISDH with a thorough f/u investigation. The facility has retained a third party social services consultant firm to visit once per month for 3 months to conduct randome resident, staff and family abuse interviews using the QIS questionnaire to ensure the facility has a system in place that prevents staff to resident mistreatment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A thorough investigation was conducted on every employee (CNA #6 and all others) acused of mistreatment and the administrative staff at the facility in conjunction with corporate oversight have taken appropriate actions on each employee including: further education, progressive discipline, and terminiation. The family and resident QIS	

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	staff is monitored, the Regional Director of Operations indicated, "Night shift staff issues were not brought to our attention prior to this survey." On 07/14/2015 at 10:56 A.M., the Clinical Nurse Consultant provided a facility policy, titled, "Abuse Prevention," dated 08/21/2013, and indicated the policy was the one currently being used by the facility. The policy indicated, "...Our abuse prevention/intervention program includes, but is not necessarily limited to....d. Informing residents and family members upon the resident's admission to the facility how and to whom complaints, grievances, and incidents of abuse should be reported.... i. Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their clothing/beds, etc.)..." 3.1-28(a)		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. Staff training tools will be introduced and inserviced monthly for the next 3 months related specifically to abuse and customer service with competency testing conducted and a threshold of 90% will be mandatory on all post tests to ensure staff know how to recognize abuse, recognize staff burn out in peers, and know how to effectively handle abuse allegations and prevention. Results of interviews and results of inservicing and post testing will be reviewed by the QA committee of the facility and any trend will be brought to the committee to discuss, evaluate and add additional interventions, actions and oversight to ensure compliance. The corporate nurse consultant will conduct weekly inspections of this action plan for compliance using a CQR audit tool to ensure all pieces are performed exactly to the letter of this plan. This will be done	

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			weekly for 8 weeks, monthly after that for 3 months and the director of operations, director of clinical services and the nurse consultant will re-evaluate the oversight after that. A third party social services consultant Lacy Beyl and Associates will conduct 2 visits over the next 90 days to conduct their own QIS staff, resident and family interviews to provide independent analysis of compliance and the results will be reviewed by the director of operations, director of clinical services and the corporate nurse consultant with the facility administration team. If the results demonstrate any trends or reveal their has not been a systemic change then Lacy Beyl services will be continued until the culture of abuse prevention is integrated into the community. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to maintain a resident's dignity by not having covered their catheter drainage bag for 2 of 2 residents observed with an indwelling urinary catheter. (Resident #166 and Resident #106) Findings include: 1. During a random observation on 7/10/15 at 3:30 p.m., Resident #166 was lying in bed and the catheter drainage bag was visible to anyone standing in the hallway. The catheter bag was observed to be hanging on the side of the bed with dark yellow fluid noted in the bag.	F 0241	F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #166 and #106 were given dignity bags to cover catheter drainage bags and have not experienced any negative outcome from this alleged deficient practice. **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 with catheters have the potential to be affected by the deficient practice. Audit completed of all residents with catheters for urinary drainage	08/14/2015

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	2. During a random observation of Resident #106 on 7/14/15 at 9:50 a.m., the catheter drainage bag was hanging on the left side of the bed with a small amount of yellow fluid visible in the bag. On 7/15/15 at 10:08 a.m., the catheter drainage bag of Resident #106 was visible from the hallway and was hanging over the end of the bed. During an interview with Resident #106 on 7/16/15 at 9:45 a.m., the resident's catheter drainage bag was noted hanging over the end of the bed with yellow fluid noted in the tubing and bag. On 7/17/15 at 11:40 a.m., the catheter bag of Resident #106 was hanging over the end of the bed and was uncovered. Yellow fluid was noted in the tubing and in the bag. During an interview with Unit Manager (UM) #1 on 7/17/15 at 11:45 a.m., UM #1 indicated the privacy bag (a bag used to conceal the drainage) for Resident #106 was hanging on their electric chair and UM #1 was obtaining second privacy bag for the resident to use while in bed. During an interview with the Director of Nursing (DON) on 7/14/15 at 10:42 a.m., the DON indicated the expectation was		performed and given dignity bags. There were no adverse outcomes related to the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff educated on Catheter Drainage Covering Policy related to dignity and the expectation for a cathether drainage bag to be covered with a dignity bag at all times. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Director of Nursing/Director of Education/Unit Managers/Weekend Supervisor will audit by visual observation the placement of dignity bags over urinary catheter drainage systems 3xs a day 3 days a week x 4 weeks, 2xs a day 3 days a week x 4 weeks, 1x a day 3 days a week for 4 weeks, then monthly thereafter to ensure bags are covered at all times. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at	

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	for a catheter drainage bag to be covered with a dignity bag at all times, or a pillow case if no dignity bags were available. The DON indicated the facility did not have a policy specific to covering the catheter drainage and had privacy/dignity bags available for use with the catheter bags. 3.1-3(t)		Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure a dependent resident was provided with activities consistent with their interests for 1 of 3 residents reviewed for activities provided to cognitively impaired residents. (Resident #95) Findings include: The clinical record review, completed 7/13/15 at 12:37 p.m., indicated Resident	F 0248	F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #95 was not able to be interviewed for activity preference related to diagnosis. Resident's husband interviewed and actives of	08/14/2015

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	#95 had diagnoses including, but not limited to, dementia. An Admission Minimum Data Set (MDS) assessment dated 5/22/15, assessed Resident #95 as having a BIMS (Brief Interview for Mental Status) of 1 out of 15, indicating severe cognitive impairment. An Activity Assessment completed 5/22/15, assessed the resident's hobbies as collecting beanie babies, watching TV, naps, and family time, and preferred independent activities versus group activities. A care plan dated 5/21/15, and edited on 7/10/15, indicated the resident chose not to participate in group activities and preferred to rest in bed between meals. Interventions included encourage the resident to pursue independent activities of watching TV (television), listening to music, naps, and spending time with husband. Offer CD (compact disc) player/CDs for independent use as desired, and provide a calendar of monthly activity programs. Observation on 7/8/15 at 3:14 p.m., the resident was in bed with their eyes closed. Their spouse was at the bedside looking at newspaper. The TV was on in the room. When the resident had their eyes open, the resident did not attempt to		choice implemented and updated to care plan. **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 with cognitive impairment, BIMs (Brief Interview for Mental Status) 1-13, have the potential to be affected by the deficient practice. All residents with cognitive impairment audited and Activities Director/Activities Assistant completed updated assessment of activity preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Activity assistants #12, #13 and CNA #11 have received education related to residents rights and needs to receive activities according to their individual preferences. Activities Director/Activities Assistant and staff members were educated on providing activities to residents with cognitive impairment, and how to assess/provide activities for resident with cognitive impairment. Activities Director/Activities Assistant will attend morning clinical	

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	look at the TV. Observation on 7/9/15 at 9:45 a.m., the resident was in bed with their eyes closed. No activities consistent with the resident's preferences were present. Observation on 7/13/15 at 6:22 a.m., the resident was awake and attempting to get legs out of bed. Certified Nursing Assistant (CNA) #11 assisted the resident back into bed. No activities consistent with the resident's preferences were present. Observation on 7/14/15 at 11:48 a.m., the resident was resting with their eyes closed. Their spouse was sitting at the bedside and indicated the resident had been asleep through out the visit. No activities consistent with the resident's preferences were present. During an interview with the Activity Director (AD) on 7/14/15 at 4:45 p.m., the AD indicated Resident #95 was not currently on a scheduled one on one visitation schedule for activities. Reviewed the Daily Record of Resident Participation for July 2015, with the AD. Documentation was completed on the sheet through 7/11/15, and indicated the resident had attended occupational and physical therapy 8 days of the month, had		meeting Monday through Friday to be informed of any resident with worsening cognitive status/new admissions thus needing new activities assessment and plan. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Activities Director/Director of Nursing/Activity Assistants will review documentation and observe activity participation in cognitively impaired residents weekly indefinitely. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	movies/television 9 days of the month, and had visited with family and friends 11 days. The AD indicated the activity assistant had been working with the residents in that unit and she would have to check to see what activities the resident had been attending. During an interview with Activity Assistant #12 and Activity Assistant #13 on 715/15 at 3:54 p.m., Activity Assistant #13 indicated the resident had been invited to attend group activities especially in the mornings, but the resident had refused and had cursed at the Activity Assistant so the Activity Assistant had left the resident alone. Activity Assistant #12 indicated the Activity Assessment completed on 5/22/15, had indicated the resident preferred to visit with spouse instead of attending group activities. The activity assistants indicated the resident had been admitted to the rehabilitation unit, had been transferred to the long term care unit, and had not been reassessed for activity preferences when admitted to the long term care unit. The assistants did not indicate knowing what the resident's activity interests were. 3.1-33(a)			

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F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review, the facility failed to ensure the care plans were updated for a resident admitted to hospice services and had behaviors disrupting daily care for 1 of 25 residents' care plans reviewed. (Resident #95) Findings include: a. The clinical record review of Resident	F 0280	F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #95 care plan was updated to reflect hospice service admission. Resident # 95 care plan was updated	08/14/2015

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	#95, completed on 7/13/15 at 12:37 p.m., indicated the resident had diagnoses including, but not limited to, dementia. A current care plan dated 5/18/15, and edited on 7/10/15, indicated the resident had an established a goal through 10/10/15, of returning home with their family after rehabilitation was completed. Interventions included, but were not limited to, allow resident to maintain independence, assist with making choices as necessary, and have services or equipment arranged prior to/upon discharge. An IDT (Inter Disciplinary Team) Clinically At Risk Review dated 6/18/15 at 1:15 p.m., indicated the resident was admitted to hospice services with a diagnosis of dementia. The notation on the form indicated the care plan was reviewed and updated and the resident would be discharged from IDT. During an interview with the Social Services Director (SSD) on 7/14/15 at 4:31 p.m., the SSD indicated the discharge plan was initiated when the resident was first admitted to the facility and should have been updated when the resident was admitted to hospice services. The SSD indicated the family had planned for the resident to remain in the		to include behaviors that disrupted daily care such as; refusal of care, combativeness and/or refusal of food and fluids. Resident #95 has not experienced any negative outcome from this alleged deficient practice. **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 whom have admitted to hospice care resulting in change of discharge plans have the potential to be affected by the same alleged deficient practice. Audit of all residents on hospice performed and care plans updated as needed All resident who have behaviors that disrupt daily care such as; refusal of care, combativeness, and/or refusal of food and fluids have the potential to be affected by the same alleged deficient practice. Audit of all residents with behaviors that interfere with daily care performed and care plans updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Social Services educated on care plan updates when a resident has opted for hospice services thus	

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	facility for long term care and not return home. b. The clinical record review of Resident #95, completed on 7/13/15 at 12:37 p.m., indicated the resident had diagnoses including, but not limited to, dementia. An Admission Minimum Data Set (MDS) assessment dated 5/22/15, assessed Resident #95 as having a BIMS (Brief Interview for Mental Status) of 1 out of 15, indicating severe cognitive impairment. A nursing progress note dated 6/1/15 at 3:46 p.m., indicated the resident was not consuming food and had refused medications. The note also indicated the resident became combative when the staff attempted a dressing change. A nursing progress note dated 6/6/15 at 6:37 a.m., indicated the resident had refused fluids throughout the night. A nursing progress note dated 6/12/15 at 9:33 p.m., indicated the resident had refused all medications and food. A hospice Summary Report dated 7/1/15, assessed the resident as taking only bites and sips and fighting with all care.		changing discharge plans. Nursing staff educated on Behavior Management Program policy. Nursing staff educated on reporting and documenting behaviors that interfere with daily care. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** IDT to meet within 72 hours after a resident change to hospice status. All care plans will be updated to reflect changes and reviewed for accuracy. Residents with change of condition resulting in change of discharge plans will be reviewed a second time in weekly IDT meeting to ensure accuracy. Director of Nursing/Unit Manager/Social Services/Weekend Manger will review nursing progress notes to ensure Behavior Events are opened. IDT will review Behavior Events daily Monday through Friday and update care plans in clinical morning meeting as needed. All new or worsening behaviors will be reviewed a second time in weekly IDT meeting to ensure accuracy. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and	

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	The care plans for Resident #95 did not address refusal of care, combativeness, or refusal of food and fluids. During an interview with the Social Services Director (SSD) on 7/14/15 at 4:31 p.m., the SSD indicated the resident did not have a behavior care plan as no behavior observations had been completed for the resident. The SSD indicated the nursing staff initiated an Observation Report any time a resident experienced a new or worsening behavior and then a report was generated for discussion in the morning meeting. The SSD indicated a lack of awareness of any behavior issues with Resident #95. During an interview with a family member on 7/8/15 at 3:14 p.m., the family member indicated Resident #95 was resistant to staff providing care such as turning, repositioning, brushing teeth, and getting out of bed. The family member indicated the resident frequently swore at the staff and "tries to beat them up," while providing care. During an interview with Licensed Practical Nurse (LPN) #9 on 7/13/15 at 7:30 a.m., LPN #9 indicated the resident had been combative with care especially with a hospice aide and LPN #9 had spoken with the hospice agency to have a		then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	different care giver sent to the facility for the resident. LPN #9 indicated the change in care giver seemed to help with the level of agitation for the resident during care. During an interview with Certified Nursing Assistant (CNA) #10 on 7/16/15 at 4:28 p.m., CNA #10 indicated Resident #95, "Fights us and gets combative when we are trying to turn or change her. We have to use swabs for mouth care." On 7/13/15 at 1:10 p.m., the Director of Nursing (DON) provided the Behavior Management Program dated October 2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...Residents who demonstrate any of the following characteristics should be involved in the behavior program: Any resident demonstrating new or worsening behaviors...and should always include behaviors towards another resident, staff or visitor...It is (Corporate Name) policy to ensure that the etiology of a resident's behavior is thoroughly investigated, documented and care planned to rule out underlying causative factors that may exist outside of a medical diagnosis...." 3.1-35(d)(2)(B)			

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F 0282 SS=E Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 services were provided according to plans of care for a resident who needed a stat (immediate) medication for abdominal pain (Resident #79), a resident with an indwelling urinary catheter (Resident #166), and a resident receiving hemodialysis (Resident #118). Findings include: 1. The clinical record of Resident #79 was reviewed on 7/10/15 at 10:17 a.m. Diagnoses for the resident included, but were not limited to, intestinal obstruction. The resident was admitted to the facility on 4/13/15. A care plan dated 4/14/15, and current through 7/14/15 indicated Resident #79 was at risk for constipation related to medication use. Approaches included giving laxatives and medications per physician orders.	F 0282	F 282 483.20(K)(3)(III) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #79 was sent to the hospital on sent to the 5/10/15 and returned to facility on 5/13/15 and has had no further problems with abdominal pain nor needed additional medical intervention. Resident #166 catheter was removed from the floor and catheter care provided and resident #166 has not had a negative outcome from this deficient practice. Resident #118 fistula was assessed for thrill and bruit and observed with no signs or symptoms of infection and/or bleeding and resident #118 has not had a negative outcome from this deficient practice.	08/14/2015

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	155196	A. BUILDING 00 B. WING	07/21/2015

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	Nurses' notes indicated: 5/9/15 at 2:30 a.m., Resident #79's abdomen was distended and she was complaining of abdominal pain. The physician was notified and ordered an X-ray which was done at 4:31 a.m. The results of the X-ray indicated, "Colonic ileus [chronic/long term irritation with bowel immobility] type pattern...may represent clinical constipation." 5/9/15 at 6:20 a.m., Resident #79's physician was notified of the X-ray results. A new order was received for the resident to have only clear liquids for 24 hours and to be given a bisacodyl rectal suppository to stimulate a bowel movement. A Medication Administration Record for May 9, 2015, indicated the resident received the suppository at 9:22 a.m. Further nurses' notes indicated: 5/9/15 at 1:33 p.m., the bisacodyl suppository was ineffective and the physician was notified. The physician gave new orders for other laxatives and another suppository. 5/9/15 at 9:25 p.m., the resident had still		Resident #118 pre/post dialysis assess completed on 7/17/15 and resident #118 receives pre/post dialysis assessments by the licensed nurse per the MD order and has had no negative outcome from this deficient practice. **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 with constipation care plans requiring a STAT medication have the potential to be affected by the deficient practice. Audit of all resident with care plan for constipation with STAT (immediate) interventions reviewed. All residents with catheter care plans have the potential to be affected by the alleged deficient practice. Audit of all residents with catheter care plan for urinary drainage audited. All resident dialysis care plans have the potential to be affected by the alleged deficient practice. Audit of resident dialysis care plans performed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	not had a bowel movement and the physician was contacted. "Writer received stat [immediately] order for (2) [brand name] enemas...writer has faxed order to pharmacy as a stat order and is currently waiting arrival for administration." The next nurse's note, dated 5/10/15 at 6:14 a.m., indicated, "Pharmacy delivered enema...writer attempted give enema resident screaming in pain unable to give enema. resident stated send me home or to hospital and let me die..." The nurse indicated she had placed a call to the physician's office to notify them of resident being unable to tolerate enema. On 7/15/15 at 2:30 p.m., the DON provided a delivery slip from the facility pharmacy which indicated the enemas had been delivered to the facility on 5/10/15 at 1:05 a.m. The DON indicated she did not know why the nurse waited until 6:14 a.m., to attempt to administer the enema when it had been ordered stat and delivered by pharmacy at 1:05 a.m. A nurse's note dated 5/10/15 at 6:49 a.m., indicated the physician wanted Resident #79 to be sent to the hospital emergency room. A nurse's note dated 5/10 15 at 7:14 a.m.,		Licensed nursing staff educated on STAT medication administration Policy. Director of Nursing will be notified by Licensed Nursing staff of all physicians' orders that are ordered STAT (immediate). Director of Nursing to be notified when STAT medication arrives and is administered. Licensed Nurse to document time of administration in Progress Note. Nursing staff educated on infection control related to catheter care including CNA #2. Licensed nursing staff educated on pre and post dialysis assessments Policy and fistula assessment. Stat orders, foley catheter procedures and pre/post dialysis assessments will be reviewed daily by the clinical team to ensure the corrective system is in place and working. A weekend supervisor will oversee these processes to ensure 7 day per week compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?**	

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	indicated Resident #79 was taken in an ambulance to the hospital. On 7/15/15 at 8:55 a.m. the Director of Nursing (DON) provided an undated policy titled, Stat Orders, and indicated it was the policy currently used by the facility. The policy indicated, "...4. If a physician prescribes a medication not available in the facility emergency supply, inform the physician that the medication is not readily available. Be sure the physician is aware that his/her order will not be available until it is confirmed with the pharmacy and the timeframe may exceed two-hours. 5. DO NOT FAX a stat order. Call the pharmacy directly to give the stat medication order to the pharmacist..." 2. The clinical record review of Resident #166, completed on 7/14/15 at 10:45 a.m., indicated the resident had diagnoses including, but not limited to, urinary obstruction. A physician's order dated 6/15/15, and updated 7/8/15, indicated a indwelling urinary catheter was necessary due to urinary obstruction (blockage of the urinary tract) and unmanageable urinary retention, (a condition in which the bladder cannot completely empty urine).		Physicians Orders and Progress noted will be reviewed Monday through Friday in clinical meeting to ensure STAT orders that arrive are given immediately. Weekend Manager/Director of Nursing will review Physicians Orders and Progress notes on Saturday and Sunday to ensure STAT orders that arrive are given immediately. Director of Nursing/Director of Education/Unit Managers/Weekend Supervisor will audit by visual observation catheter tubing is not touching the floor 3xs a day 3 days a week x 4 weeks, 2xs a day 3 days a week x 4 weeks, 1x a day 3 days a week for 4 weeks, then monthly thereafter to ensure bags are covered at all times. Director of Nursing/Director of Education/Unit Managers/Weekend Supervisor will audit each new admission chart for dialysis treatment and ensure orders are in place for fistula assessment and pre and post dialysis orders to correlate with care plan with 24 hours after admission or start of dialysis treatment. Director of Nursing/Unit Manager with audit Observations (pre and post dialysis format) daily after each dialysis treatment per care plan.	

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	A care plan dated 6/17/15, indicated the resident had an indwelling urinary catheter related to urinary obstruction. Interventions included, but were not limited to, do not allow the tubing or any part of the drainage system to touch the floor. During an observation of the resident on 7/14/15 at 9:50 a.m., the catheter drainage bag, covered in a pillow case, was laying on the floor under the middle of the bed. The fluid in the tubing was cloudy yellow with clumps of white sediment. The resident was in the bed with eyes closed. During an interview with Certified Nursing Assistant (CNA) #2 on 7/14/15 at 9:55 a.m., CNA #2 indicated the catheter bag should be hanging from the side of the bed and not on the floor. During an interview with the Director of Nursing (DON) on 7/14/15 at 10:42 a.m., the DON indicated the expectation was for a catheter to not be placed on the floor. 3. The clinical record of Resident #118 was reviewed on 7/15/15 at 12:12 p.m. Diagnoses for the resident included, but were not limited to, end stage renal disease.		EMARS (electronic medical records) will be audited daily to ensure assessment of fistula is performed per care plan. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	Current July 2015, physician orders indicated Resident #118 received hemodialysis treatments every Monday, Wednesday, and Friday. Hemodialysis is a process by which blood flows through a tube out of the body, goes through a machine filter for cleaning, and then is returned to the body. The resident's blood is accessed through a fistula, which is a surgically created connection between a vein and an artery. A careplan for Resident #118, originating 6/12/15 and current through 10/14/15, indicated a problem of the resident being at risk for complications related to receiving dialysis treatments for end stage renal disease. Approaches included, monitor fistula for thrill and bruit every shift, observe fistula site daily for signs and/or symptoms of infection and/or bleeding. A bruit is abnormal whooshing sound heard when placing a stethoscope over the fistula. A thrill is a vibration felt around the fistula access site. A physician's order dated 6/23/15 indicated, "Complete the Pre Dialysis Assessment Observation BEFORE treatment, Mon., Wed., Fri." This form indicated assessment of the fistula, the resident's heart rate, blood pressure,			

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	temperature, respiratory status. A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Mon[day], Wed[nesday], Fri[day]." this form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center. A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection. A review of Pre and Post Dialysis Assessment Observations indicated the following: June 12: only preassessment done June 15: no assessments done June 17: no assessments done June 19: no postassessment done June 22: no postassessment done June 24: no preassessment done June 29: no postassessment done July 1 no assessments done July 3: no preassessment done July 6: no preassessment done July 8: no assessments done July 10: no postassessment done			

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	July 13: no preassessment done July 15: no post assessment done The Medication Administration Records for June, 2015, indicated the facility did not begin to check the resident's fistula site until June 26. On 7/16/15 at 3:45 p.m. the Director of Nursing (DON) indicated she was not sure why the resident's fistula was not checked for bruit, thrill, and signs and symptoms of infection, according to his careplan. She indicated the above missing assessments, "apparently weren't done." On 7/16/15 at 4:00 p.m. the DON provided a policy titled Hemodialysis, dated April 2008, and indicated it was the policy currently used by the facility. The policy indicated, "...Assessment: 1. Complete the Dialysis Communication Sheet prior to dialysis, send to dialysis. Dialysis will complete their section to and after return the sheet to the facility. The facility will then complete the final assessment post dialysis..." 3.1-35(g)(2)			
F 0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR			

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Bldg. 00	HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure pre and post assessments were completed for a resident receiving dialysis treatments (Resident #118) and failed to ensure insulin was administered as prescribed for a resident who was prescribed insulin injections (Residents #78). Findings include: 1. The clinical record of Resident #118 was reviewed on 7/15/15 at 12:12 p.m. Diagnoses for the resident included, but were not limited to, end stage renal disease. The current July 2015, physician's ordered indicated Resident #118 received hemodialysis treatments every Monday, Wednesday, and Friday. Hemodialysis is a process by which blood flows through a tube out of the body, goes through a machine filter for cleaning, and then is returned to the body. The resident's blood is accessed through a fistula, which is a surgically created connection	F 0309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #118 pre/post dialysis assess completed on 7/17/15 and resident #118 has not had any adverse outcome related to this deficient practice. Resident #78 blood sugar and vitals checked every 4 hours x 2, then every shift x 2 shifts. No adverse outcomes related to deficient practice. Medication Error form filled out by DNS. MD notified. Resident own responsible party. **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 receiving dialysis treatment have the potential to be	08/14/2015

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	between a vein and an artery. A careplan for Resident #118, originating 6/12/15 and current through 10/14/15, indicated a problem of the resident being at risk for complications related to receiving dialysis treatments for end stage renal disease. Approaches included, monitor fistula for thrill and bruit every shift, observe fistula site daily for signs and/or symptoms of infection and/or bleeding. A bruit is abnormal whooshing sound heard when placing a stethoscope over the fistula. A thrill is a vibration felt around the fistula access site. A physician's order dated 6/23/15 indicated, "Complete the Pre Dialysis Assessment Observation BEFORE treatment, Mon., Wed., Fri." This form indicated assessment of the fistula, the resident's heart rate, blood pressure, temperature, respiratory status. A physician's order dated 6/23/15 indicated, "Complete the Post Dialysis Assessment Observation AFTER treatment, Mon[day], Wed[nesday], Fri[day]." This form indicated assessment of the fistula, heart rate, blood pressure, respiratory status and any reports or communications from the dialysis center.		affected by the deficient practice. Audit of residents on dialysis performed and order for Pre and Post assessment completed. All residents on hall that RN worked on 7/13/15 had the potential to be affected by the deficient practice. All MARs for 7/13/15 reviewed and MD/family were notified of any missed insulin administrations. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nursing staff educated on Pre and Post Dialysis Assessment Policy. RN placed back in orientation on 7/14/15 and checked off on Diabetic Screen in Matrix (electronic medical administration record). Licensed Nurses re-educated on Diabetic Screen in Matrix. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Director of Nursing/Unit Manager with audit Observations (pre and post dialysis format) daily after each dialysis indefinitely.	

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	A physician's order dated 6/26/15, indicated the resident's fistula was to be auscultated (listened to) for bruit, and palpated (touched) for thrill every shift, checked for signs and symptoms of infection. A review of Pre and Post Dialysis Assessment Observations indicated the following: June 12: only preassessment done June 15: no assessments done June 17: no assessments done June 19: no postassessment done June 22: no postassessment done June 24: no preassessment done June 29: no postassessment done July 1 no assessments done July 3: no preassessment done July 6: no preassessment done July 8: no assessments done July 10: no postassessment done July 13: no preassessment done July 15: no post assessment done The Medication Administration Records for June, 2015, indicated the facility did not begin to check the resident's fistula site until June 26. On 7/16/15 at 3:45 p.m. the Director of Nursing (DON) indicated she was not sure why the resident's fistula was not		Staff Development Coordinator/Director of Nursing will perform a medication check off, including Diabetic Screen, with each new Licensed Nurse during orientation to ensure understanding that Diabetic Treatments are under a separate administration tab from routine medications. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	checked for bruit, thrill, and signs and symptoms of infection, according to his careplan. She indicated the above missing assessments, "apparently weren't done." On 7/16/15 at 4:00 p.m. the DON provided a policy titled Hemodialysis, dated April 2008, and indicated it was the policy currently used by the facility. The policy indicated, "...Assessment: 1. Complete the Dialysis Communication Sheet prior to dialysis, send to dialysis. Dialysis will complete their section to and after return the sheet to the facility. The facility will then complete the final assessment post dialysis..." 2. A clinical record review for Resident #78 on 7/16/15 at 4:29 p.m., indicated a diagnosis of diabetes mellitus. Diabetes is a condition where the body is not able to produce enough insulin to draw sugar out of the blood and into the cells. A quarterly Minimum Data Assessment for Resident #78 indicated he was cognitively intact and independent in his decision making ability. A recapitulated physician's order for July, 2015, with an original date of 4/27/15, indicated Resident #78 was to receive Lantus Solostar insulin, 58 units twice a			

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	day at 8:00 a.m. and 5:00 p.m. A recapitulated physician's order for July, 2015, with an original date of 4/26/15, indicated the resident was to have has blood sugar checked with a finger stick 4 times per day, and receive NovoLog insulin depending on the results of his blood sugar checks, at 4:00 p.m. and 8:00 p.m. During an interview on 7/15/13 at 3:15 p.m., Resident #78 indicated on the evening of 7/13/15, he did not get his blood sugar checked or receive his insulin. The Medication Administration Record for July, 2015, for Resident #78 indicated he did not receive any insulin or blood sugar checks at 4:00 p.m. or 8:00 p.m. On 7/16/15 at 8:45 a.m., the Director of Nursing indicated the nurse who was taking care of Resident #78 in the evening on 7/13/15, was new and did not realize the diabetic needs (blood sugar checks and insulin administration) were on a separate medication screen from the other medications. The nurse gave all the other medications but did not go to the diabetic screen. 3.1-37(a)			

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F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy tube received appropriate treatment and services during medication administration, according to current standards of practice and facility policy for 1 resident who was observed receiving medications through a gastrostomy tube. (Resident #172.) Findings include: The clinical record of Resident #172 was reviewed on 7/14/15 at 2:05 p.m.	F 0322	F322 483.25(g)(2) NG TREATMENT SERVICES-RESTORE EATING SKILLS **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #172 given medications per gastrostomy tube as ordered. Tube flushed and not clogged and resident #172 is receiving medications per the gastrostomy tube routinely and has had no negative outcome related to this incident.	08/14/2015

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	155196	A. BUILDING 00 B. WING	07/21/2015

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	Diagnoses for the resident included, but were not limited to, aspiration pneumonia and gastrostomy tube. A gastrostomy tube is a tube placed surgically through the abdominal wall into the stomach, used for feeding and/or administering medications. During a medication administration observation on 7/13/15 at 7:22 a.m., Licensed Practical Nurse (LPN) #3 placed the following medication tablets, ordered by the resident's physician to be given through the gastrostomy tube, into a clear plastic envelope: amlodipine 5 milligrams (mg) medication used to treat high blood pressure calcium 600 mg + vitamin D(3) 400 units cranberry fruit tablet 500 mg vitamin B12 1000 micrograms digoxin 125 micrograms medication used to treat heart failure furosemide 20 mg medication used to treat heart failure and high blood pressure hydralazine 25 mg medication used to treat high blood pressure lutein 10 mg a vitamin LPN #3 then placed the envelope with all the medications into a pill crusher and ground them up until they were a powdery substance.		**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 resident with gastrostomy tubes as means of medication administration have the potential to be affected by the alleged deficient practice. Resident #172 the only resident with gastrostomy tube as means of medication administration. There were no adverse outcomes related to the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** LPN #3 immediately educated on gastrostomy tube medication administration by Nurse Consultant on 7/14/15. All Licensed nursing staff including LPN #3 educated on g-tube medication administration with documented completion of understanding by successful return demonstration. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?**	

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	The LPN took the powdery medication mixture into the resident's room, unclamped the end of the resident's gastrostomy tube, inserted a 30 milliliter (ml) syringe into the end of the tube, and flushed the tube with 30 ml of water. When all the water had drained out of the tube into the resident's stomach, LPN #3 poured the dry powdery mixture of the resident's medications into the syringe and poured some water on top of the dry mixture. The dry mixture of medications clumped at the bottom of the syringe and did not go through the gastrostomy tube into the resident's stomach. LPN #3 then picked up a plunger and gently pushed some of the mixture through, added more water, plunged again, removed the syringe and poured water through it into a cup to try to get the medication clumps which had stuck to the side of the syringe. When all the medication clumps were in the cup, LPN #3 then put the syringe back into the end of the gastrostomy tube and poured the remaining medication into the tube and kept adding water until all the medication was through. The Geriatric Medication Handbook, Eighth Edition, indicated, " Medication Administration Via Enteral Tubes ... 6. Prepare medications for administration.		Director of Nursing, SCD, UM with observe when gastrostomy tube available medication administration by Licensed Nursing Staff 3 xs a week x 4 weeks, 2xs a week x 4 weeks, 1x a week x 4 weeks, then monthly thereafter. If gastrostomy tube is not available for return demonstration the above monitoring will continue using props in clinical lab. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction	

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	a. Crush immediate-release tablets into a fine powder then dissolve in 30ml of warm water, or prescribed amount.. b. Open immediate-release capsules, crush contents into a fine powder, and dissolve in 30ml of warm water, or prescribed amount. c. Aspirate soft gelatin capsules, remove contents using a needle and syringe, and mix with 10-30ml (30ml may be needed if contents are viscous) of warm water, or prescribed amount. d. Dilute liquid medications with 10-30ml (30ml may be needed if contents are viscous) of warm water, or prescribed amount. ... 12. Put 15-30ml of water in syringe and flush tubing using gravity flow. Clamp tubing after the syringe is empty, allowing water to remain in the tube. 13. Pour dissolved/diluted medication in syringe and unclamp tubing, allowing medication to flow by gravity. 14. Flush tubing with 15-30ml of water, or prescribed amount. (If administering more than one medication, flush with 5ml of water, or prescribed amount, between each medication.) Allow water to remain in tubing. 15. Clamp tubing and detach syringe..." On 7/13/15 at 9:20 a.m., the Director of Nursing (DON) provided an undated, "Licensed Nurse Administration of Medications via Feeding Tubes Clinical Skills Validation." The DON indicated			

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	this was regarded as the current policy for administering medications through a gastrostomy tube. The skills validation indicated, "..12. Pour all medications separately, 20. Crushed all medications separately...42. Gave each medication separately to prevent clogging, rinsing the tube with 5-10 cubic centimeters of warm water between medications..." On 7/13/15 at 9:23 a.m. the DON and Clinical Consultant indicated the medication pills should have been crushed separately and mixed with water prior to putting the medication in the gastrostomy tube. 3.1-44(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure identification of root cause for falls and failed to ensure fall prevention interventions had been documented on care assignment sheets to prevent falls for 1 of 3 residents reviewed for accidents.	F 0323	F323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	08/14/2015

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	(Resident #166) Findings include: The clinical record review of Resident #166, completed on 7/14/15 at 10:45 a.m., indicated the resident had diagnoses including, but not limited to, Alzheimer's disease (a progress neurological disease causing severe dementia). An Admission Minimum Data Set (MDS) assessment completed 6/23/15, assessed the resident as having a BIMS (Brief Interview for Mental Status) of 2 out of a possible 15, indicating severe cognitive impairment. The assessment indicated the resident required extensive assistance of 2 staff for bed mobility and transfers. A care plan dated 6/15/15, indicated the resident was at risk for falling and fall related injuries related to weakness and impaired mobility. Interventions included, but were not limited to, cue/remind resident to utilize call light to seek assistance as needed, keep call light in reach, keep personal items and frequently used items within reach, and provide non-skid footwear. A Fall Event form dated 7/4/15 at 4:30 p.m., indicated Resident #166 was in the		Resident #166 falls reviewed for root cause analysis resident #166 has had no negative outcomes related to this deficient practice. Resident #166 Care Assignment Sheet updated with all fall prevention interventions **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 who sustain a fall have the potential to be affected by the same deficient practice. Audit of all falls for last 30 days completed and root cause analysis reviewed and care plans/care assignment sheets updated as needed. Audit of all resident fall prevention interventions listed on care plan reviewed for accuracy and effectiveness and care assignment sheet updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Licensed nursing staff educated on the Fall Policy. The Director of Nursing will be notified immediately of each fall and ensure that the fall incident report and the 5 Why's	

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	dining room waiting for dinner and moved from the seat of the "broad" (Broda) chair to the foot area of the chair, residing on the resident's bottom. An assessment completed at the time of the fall indicated the resident was alert and oriented, was chair bound, had no injuries, and had no interventions in place for fall prevention at the time of the fall. The immediate intervention was to have foot pedals applied to the chair. The assessment did not identify a root cause for the fall. A new care plan intervention dated 7/4/15, indicated Resident #166 would be laid down after meals. A nursing progress note dated 7/9/15 at 7:35 a.m., indicated the resident had attempted to climb out of bed several times and had been up in a chair for supervision. A Fall Event form dated 7/9/15 at 9:44 p.m., indicated the resident was found on the floor beside the bed on a non-skid mat. An assessment indicated no injuries, intermittent confusion, chair bound, and the intervention in place at the time of the fall was noted as a non-skid mat at the bedside. The assessment did not identify a root cause for the fall. The new intervention was to		(facility root cause analysis tool) is completed promptly at the time of fall. **How the corrective actions will be monitored to ensure** the deficient practice will not recur, what quality assurance program will be put into place? IDT to review each fall root cause analysis tool Monday through Friday to ensure appropriate intervention and assessment. Weekend Manager to review fall root cause analysis for falls occurring on weekend and ensure appropriate intervention. Care plan and care assignment sheet will be updated in morning clinical meeting by IDT after reviewing root cause analysis. IDT will perform second review weekly during IDT weekly meeting to ensure all documentation. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible	

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	offer food and or drink, clear pathways, and to bring the resident in to the hallway with the staff. A care plan intervention dated 7/10/15, indicated the resident would be moved to a different environment in sight of staff when the resident was restless. On 7/13/15 at 1:10 p.m., a review of the B Wing CNA (Certified Nursing Assistant) Assignment Sheet dated 7/12/15, indicated Resident #166 required 2 assist for transfers and under the column for precautions indicated to turn and reposition. The CNA assignment sheet lacked fall prevention interventions including offer to lay down after meals, move to a different environment in sight of staff when restless, and the mat beside the bed was not listed. During an interview with the DON on 7/14/15 at 3:30 p.m., the DON indicated all of the fall prevention interventions should be listed on the CNA assignment sheets. On 7/13/15 at 1:10 p.m., the Director of Nursing (DON) provided an undated policy titled Fall Management Program, and indicated the policy was the one currently used by the facility. The policy		in ensuring compliance in this Plan of Correction.	

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	indicated, "...Fall risk residents will be identified on the C.N.A. [Certified Nursing Assistant] assignment sheet listing the fall interventions...Following each fall the plan of care must be updated with the interventions based on the root cause of the fall...." 3.1-45(a)(2)			
F 0333 SS=G Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident experiencing abdominal pain received a "stat" (immediately) medication as indicated by physician order for 1 of 1 resident reviewed for significant medication error. (Resident #79) Findings include: The clinical record of Resident #79 was reviewed on 7/10/15 at 10:17 a.m. Diagnoses for the resident included, but were not limited to, intestinal obstruction. A care plan dated 4/14/15 and current through 7/14/15, indicated Resident #79	F 0333	F333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #79 was sent to the 5/10/15 and returned to facility on 5/13/15. Licensed Nurse given counseling for late administration of STAT (immediate) medication. **How other residents having the potential to be affected by the same deficient practice will be**	08/14/2015

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	was at risk for constipation related to medication use. Approaches included giving laxatives and medications per physician orders. Nurses' notes indicated: 5/9/15 at 2:30 a.m., Resident #79's abdomen was distended and she was complaining of abdominal pain. The physician was notified and ordered an X-ray which was done at 4:31 a.m. The results of the X-ray indicated, "Colonic ileus [chronic/long term irritation of bowel immobility] type pattern...may represent clinical constipation." 5/9/15 at 6:20 a.m., Resident #79's physician was notified of the X-ray results. A new order was received for the resident to have only clear liquids for 24 hours and to be given a bisacodyl rectal suppository to stimulate a bowel movement. A Medication Administration Record for May 9, 2015, indicated the resident received the suppository at 9:22 a.m. Further nurses' notes indicated: 5/9/15 at 1:33 p.m., the bisacodyl suppository was ineffective and the physician was notified. The physician		**identified and what corrective action will be taken?** All residents with STAT (immediate) ordered medications have the potential to be affected by the deficient practice. Physicians Orders reviewed for month for past 30 days reviewed for STAT (immediate) orders and time given. MD notified of all late administrations. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed Nursing staff educated on the admiration of STAT orders per policy. Director of Nursing will be notified by Licensed Nursing staff of all physicians' orders that are ordered STAT (immediate). Director of Nursing to be notified when STAT medication arrives and is administered. Licensed Nurse to document time of administration in nursing progress noted. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into**	

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	gave new orders for other laxatives and another suppository. 5/9/15 at 9:25 p.m., the resident had still not had a bowel movement and the physician was contacted. "Writer received stat order for (2) [brand name] enemas...writer has faxed order to pharmacy as a stat order and is currently waiting arrival for administration." The next nurse's note, dated 5/10/15 at 6:14 a.m. indicated, "Pharmacy delivered enema...writer attempted give enema resident screaming in pain unable to give enema. resident stated send me home or to hospital and let me die..." The nurse indicated she had placed a call to the physician's office to notify them of resident being unable to tolerate enema. On 7/15/15 at 2:30 p.m., the DON provided a delivery slip from the facility pharmacy which indicated the enemas had been delivered to the facility on 5/10/15 at 1:05 a.m. The DON indicated she did not know why the nurse waited until 6:14 a.m., to attempt to administer the enema when it had been ordered stat and delivered by pharmacy at 1:05 a.m. A nurse's note dated 5/10/15 at 6:49 a.m., indicated the physician wanted Resident #79 to be sent to the hospital emergency		**place?** Physicians Orders and Progress noted will be reviewed Monday through Friday in clinical meeting to ensure STAT orders that arrive are given immediately. Weekend Manager/Director of Nursing will review Physicians Orders and Progress notes on Saturday and Sunday to ensure STAT orders that arrive are given immediately. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	room. A nurse's note dated 5/10 15 at 7:14 a.m., indicated Resident #79 was taken in an ambulance to the hospital. Hospital emergency room notes, dated 5/10/15 at 7:47 a.m., indicated, "Final Impression 1. Abdominal pain 2. Pseudo-obstruction of intestine [the inability of intestines to contract and push food, stool and air through the gastrointestinal tract]..." A hospital History and Physical, dated 5/10/15, indicated, "...woman...transferred from ECF [extended care facility] in the setting of progressive abdominal distention. She has had difficulty with progressive constipation...for the past 2-3 weeks, now with progressive pain...she is admitted for further care..." Resident #79 returned to the facility on 5/13/15. On 7/15/15 at 8:55 a.m. the Director of Nursing (DON) provided an undated policy titled, Stat Orders, and indicated it was the policy currently used by the facility. The policy indicated, "4. If a physician prescribes a medication not available in the facility emergency			

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	supply, inform the physician that the medication is not readily available. Be sure the physician is aware that his/her order will not be available until it is confirmed with the pharmacy and the timeframe may exceed two-hours. 5. DO NOT FAX a stat order. Call the pharmacy directly to give the stat medication order to the pharmacist..." 3.1-48(c)(2)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility			

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	must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure employees were free of a communicable disease (Licensed Practical Nurses #7 and #8) for 2 of 15 employees whose records were reviewed. Findings include: A review of employee records on 7/15/15 at 10:00 a.m. indicated the following: 1. Licensed Practical Nurse (LPN) #7 was hired on 5/21/15. The 1st step of her two-step tuberculin skin test was administered on 5/21/15. A 2nd step was not found in her record. 2. LPN #8 was hired on 4/2/15. The 1st step of her two-step tuberculin skin test was administered on 3/31/15. The 2nd step was not administered 7/9/15.	F 0441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All employees administered a two step tuberculin test and determined free from communicable disease. **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 employees of the Altenheim have the potential to be affected by the same deficient practice. All employee files audited to ensure two step tuberculin test was present in employee file.	08/14/2015

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	155196	A. BUILDING 00 B. WING	07/21/2015

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	On 7/15/15 at 10:00 a.m., the Administrator indicated all nursing staff work on both on the skilled units and on the Residential care unit. The Centers for Disease Control at www.cdc.gov. indicates in an article dated 11/26/14, titled, "Latent Tuberculosis Infection: A Guide for Primary Health Care Providers, if the 1st step is negative, a 2nd step should be administered 1-3 weeks later." On 7/17/15 at 10:20 a.m. the Director of Nursing (DON) provided an undated policy titled Pre and Post-Employment Health Screening and indicated it was the policy currently used by the facility. The policy indicated, "Testing for active tuberculosis is accomplished using the two-step Mantoux tuberculin test method recommended by the Centers for Disease Control. At minimum, the 1st Step will be administered and read prior to, or on, the employee's date of hire (i.e. the first day of work including General Orientation)..." On 7/17/15 at 10:20 a.m. the DON provided another undated policy titled Facility Information and indicated it was the policy currently used by the facility. The policy indicated, "PPD [tuberculin		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Staff Development Coordinator and Human Resources educated on Pre and Post-Employment Health Screening Policy. New orientation process implemented by Human Resources. First tuberculin skin test given on Monday before orientation and read on Wednesday, first day of orientation. Staff Development Coordinator to ensure second step is given, recorded and placed in employee file. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Director of Nursing to perform a month end review monthly of all new employees hired in that month to ensure first and second PPD are present in employee file. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once	

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	skin test] Testing for Active Tuberculosis: The first ppd step administered by the employee must be complete before the employee's hire date. Even if the hire date is only attendance of General Orientation the employee is still in the facility and in the presence of the residents..." On 7/17/15 the DON indicated she was not able to find the 2nd step tuberculin skin test for LPN #7 or a 2nd step for LPN #8 administered 2-3 weeks after the 1st step. 3.1-18(k)		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction	
F 0456 SS=E Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the dishwasher rinse temperature was maintained according to the manufacturer's guidelines for proper washing and sanitizing of dishes and utensils. Findings include:	F 0456	F456 483.7 Essential Equipment, Safe opering condition **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dishwasher was taken out of service at the time the deficient	08/14/2015

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	During an observation on 07/14/2015 at 10:22 A.M., the dishwashing machine rinse cycle reached 176 degrees Fahrenheit. The manufacturer's guidelines located on the side of the dishwashing machine indicated the rinse cycle needed to reach 180 degrees Fahrenheit. During an interview on 07/14/2014 at 10:45 A. M, the Dining Manager indicated the rinse cycle did not reach 180 degrees Fahrenheit to properly wash and sanitize dishes and utensils at that time. The Dining Manager indicated maintenance would look at the dishwashing machine. A review of the Dishmachine Temperature Chart dated June, 2015, and July, 2015, indicated the dishmachine was not working properly on June 14 and 15, 2015, and July 6 and 7, 2015. During an interview on 07/21/2015 at 11:16 A.M., the Administrator indicated the Dishmachine Temperature Chart completed by dietary three times a day were unavailable for months prior to June 2015. A review of the maintenance water temperature logs, provided by the Administrator on 07/21/2015 at 11:44		practice was identified. An outside vendor was contacted to place a booster heater on the machine to ensure proper tempratures. **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 deficient practice. The dishmachine was taken off line and repairs made. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All associate were inserviced related to the deficient practice, and the steps to be taken if the rinse temperature is not met. The systemic change will be that the dishmahine's temps will be monitored during each use to ensure proper temperature. The dishmachine has also had a booster heater added in order to ensure proper tempratures. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The dishmachine will be monitored	

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	A.M., indicated the dish machine rinse cycle was below 180 degrees Fahrenheit on February 16, March 9 and 23, April 6, June 5, 8, 22, and 29, and July 6, 2015. On 7/21/15 at 11:44 a.m. the Administrator provided an undated policy titled Warewashing (Commercial Dishmachine), and indicated it was the policy currently used by the facility. The policy indicated, "...A commercial dishmachine certified by the National Sanitation Foundation is used following manufacturer's guidelines for proper washing and sanitizing of dishes and utensils....2. The dishmachine is operated following standards for temperatures and sanitizing agents as follows: Conventional Machine Wash Cycle 150 - 160'F Rinse Cycle 180'F...." 3.1-19(bb)		dialy by the Dining Services Director or designee 3 times per day for 15 days, then 5 days per week for 30 days, and lastly 3 times per week for 30 days. The results will be reviewed at the Community's QAPI meeting monthly. The Community will then monitor tempratures quarterly as part of the Community's QAPI program. Compliance date: 8/14/2015.	
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training planned in advance for all personnel. This	F 9999	F9999 **What corrective actions will be accomplished for those residents found to have been affected by the**	08/14/2015

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	training shall include, but not be limited to, the following: (6) Care of cognitively impaired residents. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing staff received the required 3 hours of annual training for dementia and annual training during the calendar year for 2 of 12 nursing staff employee files reviewed. (Certified Nursing Assistants #4 and #6, Qualified Medication Aide #5) Findings include: Employee files were reviewed on 7/15/15 at 10:00 a.m. with the following findings: 1. Certified Nursing Assistant (CNA) #6 was hired on 8/6/2010. One hour of dementia training was documented on 3/26/15. All other dementia training was documented in 2013. 2. Qualified Medication Assistant #5 was hired on 7/3/14. One hour of dementia training was documented on 4/16/15 and 1 hour on 3/19/15. No other dementia training was documented in her employee file.		**deficient practice?** No resident was found to be affected by the deficient practice. All employees completed yearly dementia and abuse training. **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 residing in facility have the potential to be affected by the deficient practice. All employee files audited by Staff Development Coordinator to ensure completion of annual abuse and 3 hours of dementia training. Employees updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Staff educated on the dementia and abuse requirements. Abuse training and dementia training to be completed prior to training for employee position. Staff Development Coordinator will track abuse and dementia training ensuring that employee files are up to date.	

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	On 7/17/15 at 10:20 a.m. the Director of Nursing provided an undated policy titled Inservice Education and indicated it was the policy currently used by the facility. The policy indicated, "Ongoing Training All employees will be required to complete a minimum of two (2) courses each month in the.....Learning System. Courses will be assigned in the following subject matters throughout the year: ...Needs of Specialized Populations Alzheimer's/Dementia (minimum three one-hour curses per year)."		**How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Director of Nursing will audit abuse and dementia training monthly for second check to ensure all employee in-services are current. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 71	R 0000	This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living	

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	Residential Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5.		Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure 1 awake staff	R 0117	**What corrective actions will be accomplished for those residents found to have been**	08/14/2015

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	person with current cardiopulmonary resuscitation (CPR) and first aid certificates was on site at all times for 20 of 42 shifts reviewed. Findings include: A review of daily staffing sheets (which indicated staff who actually worked) dated 7/6/15 - 7/19/15 indicated the following: 7/6: 2nd shift - no first aid coverage 3rd shift - no first aid or CPR coverage 7/7: 3rd shift - no first aid or CPR coverage 7/8: 2nd shift - no first aid or CPR coverage 3rd shift - no first aid or CPR coverage 7/10: 1st shift - no first aid coverage 2nd shift - no first aid coverage 3rd shift - no first aid or CPR coverage 7/11: 1st shift - no first aid coverage 3rd shift - no first aid or CPR coverage 7/12: 1st shift - no first aid or CPR		**affected by the deficient practice?** No resident was found to be affected by the deficient practice. **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 residing on the Assisted Living have the potential to be affected by the deficient practice. Audit of all nurses, certified nursing assistants, and QMAs for CPR and First Aid completion. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Assisted Living staff educated about CPR and First Aid requirements. CPR class held for Assisted Living staff on 7/23/15. Assisted Living staff to be First Aid Certified by 8-14-15. Staff Development Coordination to track CPR and First Aid completion to ensure all staff working on Assisted Living has timely renewal. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Staffing Sheet to be checked daily by Staffing Coordinator with CPR and First Aid written by staff member name that is working per shift to ensure at least one staff on all shifts has completed both	

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	coverage 3rd shift - no first aid or CPR coverage 7/15: 2nd shift - no first aid coverage 3rd shift - no first aid or CPR coverage 7/16: 2nd shift - no first aid coverage 3rd shift - no first aid or CPR coverage 7/17: 2nd shift - no first aid or CPR coverage 3rd shift - no first aid or CPR coverage 7/18: 2nd shift - no first aid or CPR coverage 7/19: 2nd shift - no first aid or CPR coverage On 7/15/15 at 11:35 a.m. the Clinical Consultant indicated the above shifts were without CPR and/or first aid coverage. She indicated the facility has a Quality Assessment Action Plan regarding these certification coverages which will be put into place as soon as the facility has a Staff Development Coordinator.		components. DON will review staffing sheets daily indefinitely. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance			

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	by written signature. Based on record review and interview, the facility failed to ensure nursing staff received the required 3 hours of annual training for dementia and annual training for abuse during the calendar year for 3 of 12 nursing staff employee files reviewed. (Certified Nursing Assistants #4 and #6, Qualified Medication Aide #5) Findings include: Employee files were reviewed on 7/15/15 at 10:00 a.m. with the following findings: 1. Certified Nursing Assistant (CNA) #4 was hired on 5/1/2010. Her last abuse training was documented on 7/8/14. 2. CNA #6 was hired on 8/6/2010. One hour of dementia training was documented on 3/26/15. All other dementia training was documented in 2013. 3. Qualified Medication Assistant #5 was hired on 7/3/14. One hour of dementia training was documented on 4/16/15 and 1 hour on 3/19/15. No other dementia training was documented in her employee file. On 7/17/15 at 10:20 a.m. the Director of	R 0120	R120 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No resident was found to be affected by the deficient practice. All employees completed yearly abuse and dementia training.**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 residing in facility have the potential to be affected by the deficient practice. All employee files audited by Staff Development Coordinator to ensure completion of annual abuse and 3 hours of dementia training. Employees updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Staff educated on the dementia and abuse requirements. Abuse training and dementia training to be completed prior to training for employee position. Staff Development Coordinator will track abuse and dementia training ensuring that employee files are up to date. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance**	08/14/2015

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	Nursing provided an undated policy titled Inservice Education and indicated it was the policy currently used by the facility. The policy indicated, "Ongoing Training All employees will be required to complete a minimum of two (2) courses each month in the.....Learning System. Courses will be assigned in the following subject matters throughout the year: Residents' Rights and Abuse Prevention...Needs of Specialized Populations Alzheimer's/Dementia (minimum three one-hour curses per year)."		**program will be put into place?** Director of Nursing will audit abuse and dementia training monthly for second check to ensure all employee in-services are current. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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	tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure newly hired employees received the 2nd step of their two-step tuberculin skin tests for 2 of 5 employees whose records were reviewed for receiving their two-step tuberculin skin test as indicated by facility policy. (Licensed Practical Nurses #7 and #8) Findings include: A review of employee records on 7/15/15 at 10:00 a.m., indicated the following:	R 0121	R121 **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** No resident was found to be affected by the deficient practice. All employees administered a two step tuberculin test and determined free from communicable disease.	08/14/2015

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	a. Licensed Practical Nurse (LPN) #7 was hired on 5/21/15. The 1st step of her two-step tuberculin skin test was administered on 5/21/15. A 2nd step was not found in her record. b. LPN #8 was hired on 4/2/15. The 1st step of her two-step tuberculin skin test was administered on 3/31/15. The 2nd step was not administered 7/9/15. On 7/15/15 at 10:00 a.m. the Administrator indicated all nursing staff work on both on the skilled units and on the Residential care unit. The Centers for Disease Control at www.cdc.gov. indicates in an article dated 11/26/14, titled, "Latent Tuberculosis Infection: A Guide for Primary Health Care Providers, if the 1st step is negative, a 2nd step should be administered 1-3 weeks later." On 7/17/15 at 10:20 a.m. the Director of Nursing (DON) provided an undated policy titled Pre and Post-Employment Health Screening and indicated it was the policy currently used by the facility. The policy indicated, "Testing for active tuberculosis is accomplished using the two-step Mantoux tuberculin test method recommended by the Centers for Disease		**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 employees of the Altenheim have the potential to be affected by the same deficient practice. All employee files audited by Staff Development Coordinator to ensure two step tuberculin test was present in employee file. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Staff Development Coordinator and Human Resources educated on Pre and Post-Employment Health Screening Policy. New orientation process implemented by Human Resources. First tuberculin skin test given on Monday before orientation and read on Wednesday, first day of orientation. Staff Development Coordinator to ensure second step is given, recorded and placed in employee file. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality**	

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	Control. At minimum, the 1st Step will be administered and read prior to, or on, the employee's date of hire (i.e. the first day of work including General Orientation)..." On 7/17/15 at 10:20 a.m. the DON provided another undated policy titled Facility Information and indicated it was the policy currently used by the facility. The policy indicated, "PPD [tuberculin skin test] Testing for Active Tuberculosis: The first ppd step administered by the employee must be complete before the employee's hire date. Even if the hire date is only attendance of General Orientation the employee is still in the facility and in the presence of the residents..." On 7/17/15 the DON indicated she was not able to find the 2nd step tuberculin skin test for LPN #7 or a 2nd step for LPN #8 administered 2-3 weeks after the 1st step.		**assurance program will be put into place?** Director of Nursing to perform a month end review of all new employees hired in that month to ensure first and second PPD are present in employee file. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	1. Based on observation, interview, and record review, the facility failed to ensure the dishwasher rinse temperature was maintained according to the manufacturer's guidelines for proper washing and sanitizing of dishes and utensils and failed to maintain ceiling vents, tiles, and walls in the pantry areas in clean condition and good repair for 2 of 2 pantry areas.. Findings include: 1.) During an observation on 07/14/2015 at 10:22 A.M., the dishwashing machine rinse cycle reached 176 degrees	R 0148	**R148 Sanitation and Safety standards** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dishwasher was taken out of service at the time the deficient practice was identified. An outside vendor was contacted to place a booster heater on the machine to ensure proper tempratures. **How other residents having the potential to be affected by the same deficient practice will be**	08/14/2015

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	Fahrenheit. The manufacturer's guidelines located on the side of the dishwashing machine indicated the rinse cycle needed to reach 180 degrees Fahrenheit. During an interview on 07/14/2014 at 10:45 A. M, the Dining Manager indicated the rinse cycle did not reach 180 degrees Fahrenheit to properly wash and sanitize dishes and utensils at that time. The Dining Manager indicated maintenance would look at the dishwashing machine. A review of the Dishmachine Temperature Chart dated June, 2015 and July, 2015, indicated the dishmachine was not working properly on June 14 and 15, 2015, and July 6 and 7, 2015. During an interview on 07/21/2015 at 11:16 A.M., the Administrator indicated the Dishmachine Temperature Chart completed by dietary three times a day were unavailable for months prior to June 2015. A review of the maintenance water temperature logs, provided by the Administrator on 07/21/2015 at 11:44 A.M., indicated the dish machine rinse cycle was below 180 degrees Fahrenheit on February 16, March 9, 23, April 6,		**identified and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. The dishmachine was taken off line and repairs made. The panties in question have been cleaned according to standards. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All associate were inserviced related to the deficient practice, and the steps to be taken if the rinse temperature is not met, and the cleaning schedules for the panties identified during the survey. The systemic change will be that the dishmahine's temps will be monitored during each use to ensure proper temperature. The dishmachine has also had a booster heater added in order to ensure proper tempratures. A cleaning schedule related to the panties and standards of practice have been instituted to ensure the deficient practice does not recur. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The dishmachine will be monitored	

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	June 5, 8, 22, 29, and July 6, 2015. On 7/21/15 at 11:44 a.m. the Administrator provided a policy titled Warewashing (Commercial Dishmachine) and indicated it was the policy currently used by the facility. The policy indicated "...A commercial dishmachine certified by the National Sanitation Foundation is used following manufacturer's guidelines for proper washing and sanitizing of dishes and utensils....2. The dishmachine is operated following standards for temperatures and sanitizing agents as follows: Conventional Machine Wash Cycle 150 - 160'F Rinse Cycle 180'F...."		dialy by the Dining Services Director or designee 3 times per day for 15 days, then 5 days per week for 30 days, and lastly 3 times per week for 30 days. The results will be reviewed at the Community's QAPI meeting monthly. The Community will then monitor tempratures quarterly as part of the Community's QAPI program. The pantried will be monitored daily by the Dining Services Director or designee 5 days per week for 30 days, and 3 times per week for 30 days. The results will be reviewed at the Community's QAPI meeting monthly. The Community will then monitor sanitation records quarterly as part of the Community's QAPI program. Compliance date: 8/14/2015.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. 1. Based on record review and interview,	R 0349	**R 349**	08/14/2015

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	the facility failed to ensure resident clinical records were documented with physician notification of weights and blood sugars outside physician call parameters for 1 of 7 records reviewed for documentation (Resident # 509) and the facility failed to accurately document the code status for a resident requesting a DNR (Do Not Resuscitate) status for 1 of 7 residents reviewed (Resident #353). Findings include: 1.) The clinical record of Resident #509 was reviewed on 7/20/15 at 10:00 a.m. Diagnoses for the resident included, but were not limited to diabetes mellitus and end stage kidney disease. A current physician's order, dated 6/13/15, indicated the resident was supposed to be weighed daily and the physician notified if the resident gained more than 3 pounds (lbs) in 1 day or 5 lbs in 1 week. Review of the resident's daily weights for July, 2015, indicated he gained 4.4 lbs between 7/2/15 and 7/3/15, and he gained 6 lbs between 7/11/2015 and 7/12, 2015. There was no documentation in the resident's record which indicated the physician had been notified of these		**How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Resident #509 blood sugars and daily weights were reported to MD. Daily weights discontinued on #509. No adverse outcomes related to deficient practice. Resident #535 Do Not Resuscitate (DNR) was clarified by Physicians Order, updated on Face Sheet, updated on the Continuity of Care page, Service Plan and Functional Assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Audit of residents on daily weight performed x past 30 days. MD notified of any weight required by call parameters. Audit of diabetic residents blood sugar readings x past 30 days. MD notified of any blood sugar required by call parameters. Audit of Code Status to ensure Physicians Order, Face Sheet, Continuity of Care page, Service Plan and Functional Assessment are the	

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	weight gains which were over the 3 lbs per day call order parameter. A current physician's order dated 6/13/15, indicated the resident was supposed to have his blood sugar checked with a finger stick blood test before meals and at bedtime. The physician was to be notified if the blood sugar test results were less than 70 or over 300. Review of the resident's blood sugar checks for June and July, 2015, indicated the following: 6/16 at bedtime - blood sugar (bs) = 317 6/18 at bedtime - bs = 321 6/20 at bedtime - bs = 345 6/23 at bedtime - bs = 326 6/25 at 4:00 p.m. - bs = 345 6/26 at bedtime - bs = 368 6/27 at bedtime - bs = 305 6/29 at bedtime - bs = 353 6/30 at 11:00 a.m. - bs = 340 7/2 at 4:00 p.m. - bs = 308 7/3 at bedtime - bs = 310 7/5 at bedtime - bs = 313 7/11 at bedtime - bs = 305 7/16 at bedtime - bs = 314 There was no documentation in the resident's record which indicated the physician had been notified of the above blood sugars over 300.		same for all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed Nursing staff educated on Code Status Policy. Licensed Nursing Staff educated on call parameters related to blood sugar and daily weight. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Unit Manager/Director of Nursing will audit blood sugar parameters and daily weights for call order parameters 5xs a week for 4 weeks, 4xs a week for 4 weeks, 3xs a week for weeks, then monthly. Unit Manager/Director of Nursing will ensure residents code status and proper documentation of code status is in place at time of admission. Unit Manager will bring new admission charts and/or any resident who changed code status to morning clinical meeting to review for accuracy the morning after admission/change in status. Director of Nursing/Unit Manager	

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	On 7/20/15 at 3:10 p.m., the Residential Unit Manager indicated she was unable to find where the physician was notified of the above blood sugars and weights which were outside the physician's call parameter orders.2. The clinical record review of Resident #535, completed on 7/20/15 at 11:50 a.m., indicated the resident had diagnoses including, but not limited to, high blood pressure. The admission Physician's History and Physical dated 11/18/14, did not address a code status for the resident. The admission physician's orders dated 11/28/14, indicated the code status for the resident was a "Full Code." A Full Code status indicated the cardiopulmonary resuscitation would be performed in the event the heart should stop. The electronic health record for Resident #535 indicated a full code status on the face sheet and on the Continuity of Care page under advance directives. The recapitulation of physician's orders dated June 2015, indicated "Do Not Resuscitate (DNR)" under code status with an order date of 11/28/14. The Service Plan dated and signed on		will perform 10 audits of charts 3x a week for 4 weeks, 2x a week for 4 weeks, and weekly x 4 weeks. Director of Nursing will audit all Assisted Living Charts for Code Status at months end x 3 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 8/14/2015. The Administrator at Altenheim Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	

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	6/5/15, and the Functional Assessment dated 6/5/15, lacked an indication of code status. During an interview with the Unit Manager of Residential (UM) #14 on 7/20/15 at 3:20 p.m., the UM indicated the resident had signed a DNR form and the form had been signed by the physician so the facility did not write a physician's order to change the code status from full code to DNR. The DNR form was signed by the physician on 3/6/15. The UM was not able to determine when or how the code status was changed in the physician's orders. During an interview with the Director of Nursing (DON) and the Clinical Nurse Consultant on 7/20/15 at 4:20 p.m., the Clinical Nurse Consultant indicated the staff were trained to look under the tab in the hard chart (paper chart) titled Advance Directives in order to determine the code status for the resident. On 7/20/15 at 4:20 p.m., the Clinical Nurse Consultant provided the Code Status Policy dated March 31, 2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...The attending physician will be notified of each resident's resuscitative status and the nurse will write a doctor's			

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	order in the chart...The nurse will write a doctor's order for a full code or DNR even when a completed POST [Physician's Orders For Scope of Treatment] form is present upon admission...It is [Corporation Name] policy to routinely review the code status of each resident with the resident or responsible party when the plan of care is reviewed...."			