STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155428	A. BUILDING 00 B. WING	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERIDIAN NURSING AND REHABILITATION CENTER	2102 S MERIDIAN ST INDIANAPOLIS, IN 46225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 23, 24, 25, and 26, 2020 Facility number: 000386 Provider number: 155428 AIM number: 100286820 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 1 Medicaid: 32 other: 6 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on March 02, 2020.	F 0000	On February 26, 2020 a Recertification Survey was concluded at Meridian Nursing & Rehab. Enclosed, please find the statement of deficiency with the facility's plan of correction for alleged deficiency. Please accept this plan of correction as the facility's credible compliance. Meridian Nursing & Rehab request a desk review to verify the facility has achieved substantial compliance with the applicable requirements as of 03/13/2020.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

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

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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed to ensure a resident's code status preference was correctly communicated on all documents for 1 of 16 residents reviewed for advanced directives. (Resident 5)	F 0578	F578 – Request/Refuse/Discontinue Treatment: Formulate Advance Directive 1. What corrective Action will be accomplished for those residents found to have been	03/13/2020

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	Findings include: On 2/24/20 at 10:30 a.m., during a facility tour with the DON (Director of Nursing), observed Resident 5's name tag located next to the entrance door of his room. Next to his name was a "red dot." During an interview with the DON at that time, the DON indicated the "red dot" signified the resident was considered a 'no code' (meaning no life sustaining measures, including cardiopulmonary resuscitation, were to be implemented). On 2/25/20 at 8:38 a.m., the clinical record for Resident 5 was reviewed. Resident 5 was admitted to the facility on 5/13/19. The Code Classification Form, dated 5/2/19 and signed by Resident 5's guardian, indicated " ...NO CODE--C.P.R. (cardiopulmonary Resuscitation) will not be initiated." The Physician's Medication Review Report, dated 5/1/19 and current through 2/25/20, indicated Resident 5 was a "Full Code (full code to include CPR and potential transfer to hospital with physician order for possible hospital admission)." Resident 5's care plan, dated 7/3/19 with no end date noted, indicated " ...Resident has a full code status ..." Interview, on 2/24/20 at 10:40 a.m., the DON indicated Resident 5's code status documentation was inconsistent. Resident 5's guardian had chosen the 'no code' status for the resident. On 2/25/20 at 9:07 a.m., the Administrator provided a copy of the Cardiopulmonary Resuscitation (CPR) / Do Not Resuscitate (DNR) policy, dated 8/26/13, and indicated it was the		affected by the alleged deficient practice? Code status preference was discussed with resident and guardian and resident determined he wanted to be a DNR. Physician signed code status to comply with Resident's / Guardian's wishes. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No other residents were affected. Eighteen (18) residents had the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Advanced Directives written information and Code status preferences will be reviewed and discussed with every admission and revisited at every care plan meeting. When a resident request to be a DNR without a physician signed SCOPE form, form will be signed by resident / responsible party and signed by physician. Social Service Designee (SSD) or designee will notify nursing of resident desired code status	

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	current policy in use by the facility. A review of the policy indicated, " ...Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect ..." 3.1-4(f)(5)		changes / signed POST forms. Nursing will relay forms to physician for signature. Once signature is obtained and resident reverts to DNR, Social Services will update care plan and change the colored dot on resident name plate. Medical records or designee will audit 2 new admission charts weekly times four (4) weeks to ensure the most recent/accurate advanced directive choice is in the chart and coincides with the resident wishes. SSD, MDSC and nursing staff inserviced on Code Status Preferences. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? Social Services and Medical Records will utilize the QAPI Advanced Directive / Code Status Audit tool to identify deficient areas and document completion two (2) times weekly for one month; and then monthly for five months and ongoing as needed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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			5. By what date will systemic changes be completed? 3/13/2020	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and			

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	(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			

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	Based on interview and record review, the facility failed to ensure a resident was referred to the State-designated authority for a Level II Pre-Admission Screening Resident Review (PASRR) evaluation and determination for 1 of 2 residents reviewed for PASRR. (Resident 5) Findings include: On 2/25/20 at 8:38 a.m., the clinical record of Resident 5 was reviewed. Resident 5 was admitted to the facility on 5/13/19 from another long term nursing facility. Diagnosis included, but were not limited to, bipolar disorder, schizoaffective disorder, and generalized anxiety disorder. The PASRR Level I - Identification Evaluation Criteria Certification by Physician for Long-Term Care Services, was completed by the previous long term care facility on 2/5/16 and indicated Resident 5 had " ...a diagnosis of major mental illness ...was prescribed a major tranquilizer or psychoactive drug on a regular bases for a mental health condition ..." The quarterly MDS (Minimum Data Set) assessment, dated 12/6/19, indicated Resident 5 was cognitively intact. The clinical record lacked a PASRR Level II mental health assessment for Resident 5. Interview, on 2/24/20 at 10:46 a.m., the SSD (Social Services Director) indicated Resident 5's PASRR Level I was completed on 2/5/16, while at the previous long term care facility. The Level I indicated Resident 5 had serious mental health	F 0645	F645 – PASARR screening for MD and ID 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Ascend was notified and a new Level II assessment determination was received on 3/2/2020. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? An audit was completed with no other residents were affected by this alleged practice. Sixteen residents had the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? All admissions will have a copy of PASSAR documentation sent with them at time of admission. If appropriate documentation is not present at time of admit, Social Service Director (SSD) or designee will obtain appropriate documentation. Business Office	03/10/2020

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	conditions and triggered a PASRR Level II assessment. The SSD was unable to locate a completed PASRR Level II mental health assessment for Resident 5. On 2/24/20 at 3:10 p.m., the Administrator provided a copy of the Pre-Admission Screening Checklist: Level I, Level II, and Level of Care policy, dated June 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...does resident trigger a Level II ...if so, follow proper protocol to obtain ...all required documents for PASRR compliance ..." On 2/25/20 at 3:00 p.m., a review of the Indiana PASRR Level I and Level of Care Screening Procedures for Long Term Care Services Provider Manual, dated 3/8/17, indicated "when an outcome of Refer for Level II is rendered, the submitter is responsible for notifying the appropriate mental health or intellectual disability representative (based on region), who will conduct the onsite Level II evaluation ..." 3.1-16(d)(1)(A)		Manager (BOM) or designee will audit two admission ascend paperwork weekly x 1 month. SSD and BOM inserviced on appropriate ascend paperwork needed for admissions. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? Business Office Manager will utilize the QAPI PASSAR Audit tool to identify deficient areas and document completion two (2) times weekly for one month; and then monthly for five months and ongoing as needed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 3/10/2020	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure collaboration in the development and implementation of a coordinated plan of care with hospice for 1 of 1 resident reviewed for hospice care. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 2/24/20 at 1:45 p.m. Diagnosis included, but was not limited to, cirrhosis of the liver. The Hospice Informed Consent document, dated 12/4/19 and signed by Resident 10, indicated, "...I acknowledge I have read, understand and I agree to the Hospice Informed Consent/Hospice Election Benefit Statement..." The Facility Notification Form, dated 12/4/19, indicated Resident 10 had elected to receive hospice services. The Physician's Active Order Summary Report, dated 2/24/20, indicated, "...Admit to Heart to Heart Hospice with diagnosis of Cirrhosis of the liver effective 12/4/19..." The significant change MDS (Minimum Data Set) assessment, dated 12/4/19, indicated "...Prognosis...the resident has a condition or chronic disease that may result in a life expectancy of less than 6 months..." The Hospice Certification and Plan of Care, dated and signed by the Hospice Physician on 12/10/19,	F 0684	F684 – Quality of care 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 10's care plan was updated to include hospice services. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? Five (5) residents had the potential to be affected. An audit was completed, and all care plans were updated to include hospice services accordingly. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? All hospice admissions will be discussed during daily morning meeting and care plan will be	03/10/2020

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	indicated, "...Hospice nurse to coordinate plan of care with facility...Goals...a nursing plan of care will be established...facility staff is knowledgeable and involved in hospice plan of care..." Resident 10's clinical record lacked a hospice care plan. Interview, on 2/26/20 at 12:50 p.m., the Social Services Director indicated Resident 10's clinical record lacked a hospice care plan. A hospice care plan should have been developed for Resident 10. On 2/24/20 at 3:00 p.m., the Administrator provided a copy of the Care Plans - Comprehensive policy, dated September 2014, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS...reflect the resident's expressed wishes regarding care and treatment goals...identify the professional services that are responsible for each element of care...the resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS)..." 3.1-37(a)		updated accordingly. Social Services Director (SSD) or designee will audit two hospice admission charts weekly x 1 month. SSD and MDS Coordinator inserviced on procedure to include hospice care plans for all hospice residents. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? SSD and/or MDSC will utilize the QAPI Hospice Care Plan Audit tool to identify deficient areas and document completion two (2) times weekly for one month; and then monthly for five months and ongoing as needed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 3/10/2020	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility			

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	must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan that included monitoring a resident's behaviors and identifying interventions for staff to initiate to redirect behaviors for 1 of 1 resident reviewed for behaviors. (Resident 22) Findings include: 1. On 2/24/2020 from 12:45 p.m. to 1:20 p.m.., during dining observation, observed Resident 22 in the dining room. Resident 22 was heard to repeatedly yell out in a very loud tone "NO...NO...NO!" On 02/25/2020 from 8:30 a.m., to 8:45 a.m., Resident 22 was observed in the hall way. Resident 22 was heard to repeatedly yell out in a very loud tone, "NO...NO...NO!" On 02/25/2020 from 1:00 p.m., to 1:20 p.m., observed Resident 22 in hall way. Resident 22 was heard to repeatedly yell out in a very loud tone, "NO...NO...NO!" On 2/25/2020 from 2:00 p.m., the clinical record of Resident 22 was reviewed, diagnosis included, but were not limited to, cognitive communication deficit.	F 0740	F740 – Behavioral Health Services 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #22's care plans were updated to include monitoring of behaviors with appropriate interventions. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? An audit was completed of all resident behavior plans. Thirty-one (31) residents had the potential to be affected, care plans were updated accordingly. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not	03/10/2020

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	A Behavior Management Monthly Summary, dated 9/2019, indicated: Summary of Behaviors for the Month: "Yelling, hitting herself, screaming, socially inappropriate, disruptive behaviors." A quarterly Minimum Data Set assessment, dated 12/26/19, indicated Resident 22 had a severe cognitive impairment. A Health Status Note, dated 1/16/2020, indicated: "C.N.A. [Certified Nursing Assistant] brought to this Nurses [author] attention Resident 22 had some slight bruising above the right eye and on the right eye. As noted in earlier notation from 1/15/20 [Resident 22] had hit, and slapped herself yesterday afternoon." A Health Status Note, dated 1/16/2020, indicated "Late entry: On 1/15/2020, Resident 22 had appeared upset while in hall. Yelling and hitting the side of her head on the right side. This is a normal behavior for this resident when she becomes distraught or angry...It is difficult to redirect [Resident 22, name] at times when she has these behaviors." A Care plan, dated 10/18/19, and current through 5/29/20, indicated Resident 22 had "impaired cognition as evidenced by mild cognitive impairment, and intermittent explosive disorder." Goal: "Will maintain current level of cognitive functioning through next review date." The clinical record lacked an intervention that addresses behavioral monitoring and identifying interventions for staff to initiate to redirect behaviors. Interview, on 02/25/20 at 9:52 a.m., the Social		occur? Social Service Designee (SSD) or designee will review all behaviors during morning meeting to ensure behaviors are being captured and interventions in place are working and updating care plans as needed to add/change interventions. All staff were inserviced on Behavior Management and documentation of behaviors including interventions. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? SSD and/or MDSC will utilize the QAPI Behavior Management Audit tool to identify deficient areas and document completion two (2) times weekly for one month; and then monthly for five (5) months and ongoing as needed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 3/10/2020	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERIDIAN NURSING AND REHABILITATION CENTER	2102 S MERIDIAN ST INDIANAPOLIS, IN 46225

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	Services Director indicated the only behavioral monitoring sheet available was dated September 2019. "The staff only documented the behaviors when she was first admitted." Currently the staff did not document the monitoring of Resident 22's behavior. Behavioral interventions for staff to implement to redirect behaviors was not available. On 2/25/20 at 9:57 a.m., the Social Services Director provided a policy titled Behavior Management, dated December 2015, and indicated it was the current policy being used by the facility. A review of the policy indicated "Protocol: Each resident with identified behaviors ...will be monitored for episodes of behaviors. (See Behavior Management Record.). All staff are responsible for documentation on the Behavior Monitoring Form and identifying interventions initiated to redirect behaviors." 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure an open vial of tuberculin was dated at the time it had been opened, as indicated by facility policy, for 1 of 1 tuberculin vials observed in 1 of 1 medication storage rooms. Findings include: During Medication storage observation, on 02/26/2019 at 8:35 a.m., in the locked medication storage room, behind the nurses station, observed an opened vial of tuberculin in the medication storage refrigerator. The opened vial was not labeled indicating when had been opened. Interview, at that time, Qualified Medication Assistant (QMA) indicated the opened vial should have been dated and labeled, indicating the date it was opened. On 2/26/2020 at 9:30 a.m., the Administrator provided a policy, titled Storage of Medications, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated."	F 0761	F761 – Label/Store Drugs and Biologicals 1 What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No Residents were affected by this alleged practice. The vial was immediately discarded. 2 How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected. An audit of all opened vials was completed, and no other opened vials of medication were identified. 3 What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not	03/10/2020

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			occur? Director of Nursing (DON) or designee will audit medication room and med carts two (2) times weekly to ensure date open stickers are adhered to all opened vials and expired medications are discarded. Nursing personnel were inserviced on date opened stickers on all vials and when to discard. 4 How will the corrective action be monitored to ensure the alleged deficient practice will not occur? Director of Nursing (DON) or designee will utilize the QAPI Drug Vial / Date Opened Audit tool to identify deficient areas and document completion two (2) times weekly for one month; and then monthly for five (5) months and ongoing as needed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5 By what date will systemic changes be completed? 03/10/2020	

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F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple occupancy rooms. This was observed in 2 of 20 resident rooms. (Rooms 9 and 10) Findings include: Interview, on 2/23/2020 at 10:30 a.m., the Administrator indicated the following provided room sizes were current. Review of the facility's Room Size Certification, received from the Administrator on 2/23/2020 at 10:30 a.m., indicated the following: The floor area of the following multiple resident rooms measured: 1. Room 9, three beds 236" x 135" - 73.75 SQ FT per resident. SNF/NF. 2. Room 10, three beds 236" x 135" - 73.75 SQ FT per resident. SNF/NF. The facility rooms with variances were observed on 2/23/2020 at 10:45 a.m. The rooms were observed to have the following number of beds:	F 0912	F912 – Bedrooms Measure at Least 80 square FT/Resident 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The facility requests the requirement cited at F912 be waived as the noncompliance does not pose a threat to resident's health and safety. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? The deficient practice could potentially affect three (3) residents residing in room 9 and three (3) residents in room 10. 3. What measures will be put	03/10/2020

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	Room 9 - Three beds Room 10 - Three beds Interview, on 2/23/2020 at 10:30 a.m., the Administrator indicated the following provided room sizes were current. 3.1-19(l)(2)		into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The waiver is requested annually, maintained on file and available upon request to prospective residents and their representatives. The administrator is responsible for adhering to the requirements of the waiver and is responsible for oversite and practical application of policies and procedures governing the waiver. Measurements are available at any time for these rooms and waiver will be requested annually. Attachment #8 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? Residents residing in these rooms will be monitored for potential negative outcomes as a result of the room size or number of residents in the room. Negative outcomes could include, but not limited to privacy, personal belongings, and adequate nursing care. The social worker will use the QIS Resident Interview protocol to measure resident satisfaction with privacy, retention of personal belongings, and the adequacy of nursing care provided,	

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			by interviewing residents in waivered rooms monthly for six months and ongoing. The results of these interviews will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If a satisfaction threshold of 95% related to size of room or occupancy is not achieved an action plan will be developed to ensure resident satisfaction is achieved. 5. By what date will systemic changes be completed?	