STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00306026 and IN0306915. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00306026 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0686 and F0727. Complaint IN00306915 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0604 and F0740. Survey dates: September 20, 23, 24, 25, 26, and 27, 2019 Facility number: 011296 Provider number: 155763 AIM number: 200827620 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 2 Medicaid: 24 Other: 16 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 1, 2019.	F 0000		
F 0604 SS=D	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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Bldg. 00	§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.			
	Based on interview and record review, the facility failed to ensure a resident was free from physical restraint for 1 of 3 residents reviewed (Resident R). Findings include: On 9/20/19 at 12:31 P.M., Resident R's record was reviewed. Diagnoses included, but were not	F 0604	***F604*** Right to be Free from Physical Restraints - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	10/27/2019

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	limited to, dementia without behavioral disturbance, anxiety disorder, and depression. A quarterly MDS (Minimum Data Set) assessment, dated 8/23/19, indicated the resident had a BIMS (Brief Interview Mental Status) score of 4 which signified she had severely impaired cognition. The resident complained of feeling down, depressed, or hopeless 1 day during the assessment and had no behaviors. She propelled her w/c (wheelchair) in the hallway with supervision and limited assistance. Resident R indicated she had occasional pain that made it hard to sleep at night and limited her day to day activities. A Care Plan, initiated 8/29/19, indicated the resident had behaviors not directed towards others as evidenced by yelling out, wanting to go home, getting upset with staff, and agitation. She had stated that she wished she were dead. The goal was that the resident would show no behaviors. Interventions were: Explain to the resident that her behavior was inappropriate (8/29/19) and she would be placed on 1:1's and 15 minute checks (9/17/19). A facility incident report, dated 9/17/19 at 3:01 p.m., indicated 2 nurses had been in the dining room talking when Resident R entered the room in her w/c. The resident was asked to leave the area however she refused. Nurse 3 was observed to hold the residents arms down against her stomach as the nurse tried to back her out of the dining room. Nurse Notes indicated the following: 9/17/19 at 2:00 p.m., Resident R was weepy and stated she wanted to go home with her family		Facility will ensure Resident R, a safe environment free from physical restraints. Facility will ensure resident is treated with dignity and respect. - **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 have the potential to be affected by alleged deficient practice. No other resident will be affected. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nurse named in abuse allegation was suspended pending investigation and terminated when allegation was found to be substantiated. Facility will re-educate current staff along with new employees upon hire. Included but not limited to; Resident Rights Policy, Abuse and Neglect Policy, and Behavior Policy. - **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; and** Administrator or Designee will monitor Mood Changes and Behaviors daily at morning	

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	member. She was provided assistance to call the family member but there was no answer. A message was left for the family member to call the facility. 9/17/19 at 3:45 p.m., a head to toe assessment was completed on the resident to assess for injuries related to her arms being held down against her abdomen while she was involuntarily pushed out of the dining room. She had no visible injury or complaints of pain or discomfort. The resident had no recollection of the event. A written witness statement by the AIT (Administrator in Training) and dated 9/17/19, indicated the resident had been upset and wanting to call her family member. She and other staff members were trying to re-direct her and calm her down. The resident propelled herself into the dining room where 2 nurses were giving shift report, and stated she wanted to call her family member. Nurse 3 was heard to say "You're not going to yell at me like that". Nurse 3 tried to move the resident who told her to stop. Nurse 3 then "grabbed" the residents arms and restrained them up to her abdomen. A written statement by Nurse 5 (who was unavailable for interview), dated 9/17/19, indicated she had been the other nurse to whom Nurse 3 was giving report and viewed the entire incident. Her statement indicated Nurse 3, "without undue pressure or restriction, protected Resident R's arms while guiding her w/c through the doorway ensuring her arms did not brush against the door frame. Nurse 3 did not use undue force nor was she rough with the resident". On 9/20/19 at 10:35 A.M., the HR (Human Resource) Director was interviewed. During the		department meeting that occurs Monday thru Friday. Administrator or Designee to be contacted on Saturdays and Sundays to address any immediate concerns. Interdisciplinary team will review of the weekend Mood Changes and Behaviors. If changes are needed, Care plans will be updated and followed. Administrator or Designee to monitor burnout symptoms on five employees per week. Administrator or Designee will monitor five residents per week to ensure physical restraints are not being used. Staff to be educated on physical and chemical restraints. Administrator or Designee will educate Department Leadership by in-servicing and providing handouts, on the signs and symptoms of staff burnout. With tips on how to handle situations that arise due to stress. Administrator or Designee and Leadership team will monitor all staff daily. And will intervene, assist, and educate when necessary. Staff will be educated on managing work related stress and take a self-assessment questionnaire. Administrator or Designee will educate staff monthly at mandatory all staff meetings. Include education of how to recognize and handle burnout during the new orientation process. Administrator or Designee will audit weekly for four	

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	interview, she recounted her written statement and indicated she was present and observed the incident. There were 2 nurses in the dining room giving report when Resident R was observed going into the room. She told Nurse 3 she wanted to call her family member. Nurse 3 got up from the table and walked up to the resident and stated "You're not going to yell at me like that". Nurse 3 tried to move the resident out of the dining room but the resident told her not to move her. Nurse 3 then "grabbed" the resident's arms and pressed them into her stomach restraining her as she tried to back her out of the dining room. Staff intervened and removed the resident from the area. The HR Director indicated she asked Nurse 3 to leave the facility and was hereby suspended pending an investigation. Nurse 3 stated "Yes, I did put my hands on her. It's been like this all day and she (Resident R) doesn't need to be in the dining room when we give report". On 9/20/19 at 11:51 A.M., the Interim DON (Director of Nursing) was interviewed. During the interview, she indicated she had not viewed the entire incident. She witnessed the resident trying to go into the dining room when Nurse 3 approached her and told her they were giving report and she needed to leave. The DON then heard Resident R yelling and cursing. The SSD (Social Service Director) removed the resident from the dining room. The DON did not witness Nurse 3 restrain the resident's arms. She indicated that nurses should not give report in the dining room as it was the resident's right to go into that room of their home. On 9/24/19 at 11:54 A.M., the Administrator was interviewed and provided a copy of an email sent to her by Nurse 3. The email indicated the following: Resident R came into the dining room		weeks, bi-monthly for the following two months after, and monthly for the last three months. A report of progress will be forwarded to the QAPI committee for a minimum of 6 months.	

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	while she and another nurse were giving report. She and the other nurse asked her to leave and that she would be assisted when they were done. The resident began arguing with Nurse 3. She, then, "stood up, walked up to her (Resident R) and took the handles of wheelchair and attempted to redirect her out to the lounge where 6-8 feet away, stood several other people include the Social Service Director and DON". Resident R "grabbed the arm of a chair, I leaned over and used both hands to remove her hand and she immediately turned in her wheelchair and started striking and yelling at me. I held her arms at wrist level and repeated 'Stop that four or five times until she stopped attempting to hit then let go of her hands and continued removing her from the dining room". The Administrator indicated a decision was made to release the nurse from employment at the facility. Nurse 3 had completed training on Abuse and Neglect and Resident Rights on 8/8/19. The Administrator provided a copy of Nurse 3's post-training test on 8/8/19. A test question asked which 3 items residents were entitled to which Nurse 3 answered correctly which were to be free of restraints, a safe environment, and care that promotes their physical, psychological, and social well-being. The Administrator indicated training on resident rights and abuse had, again, been conducted on 9/9/19 and Nurse 3 had been present. On 9/20/19 at 11:28 A.M., the Administrator provided a current copy of the facility policy titled "Resident Abuse Policy" which stated the following: "Residents of this long-term care facility are protected from any physical, verbal and mental mistreatment by staff or visitors...Abuse is defined as any mental, sexual, verbal or physical mistreatment of a resident whether or not an actual injury occurs...Abuse			

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	includes, but is snot limited to the willful infliction of physical pain, injury, or mental anguish, sexual statements, inappropriate touching, forced sexual activity, harassment, threatening statements, yelling, derogatory or racial statement with specific intent of hurting a resident...." This Federal tag relates to Complaint IN00306915. 3.1-3(w)			
F 0686 SS=J Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on interview and record review, the facility failed to assess, monitor, and treat a resident's Stage 4 pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident V). The deficient practice resulted in the pressure ulcer increasing in size and tunneling which required the resident to be hospitalized, her wound surgically debrided and administration of intravenous antibiotics. The immediate jeopardy began on 6/21/19 when	F 0686	***F686*** Treatment/Svcs to Prevent/Heal Pressure Ulcer **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident no longer resides at facility. **how other residents having the potential to be affected by the**	10/27/2019

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	treatment for the resident's pressure ulcer was discontinued. The Regional Director of Operations, Administrator, and Interim Director of Nursing were notified of the immediate jeopardy at 12:53 p.m. on 9/25/19. The immediate jeopardy was removed on 9/27/19 but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 9/20/19 at 2:22 P.M., Resident V's record was reviewed. Diagnoses included, but were not limited to, Stage 4 pressure ulcer to the coccyx (present upon admission to the facility in 2018) and post-polio syndrome with muscle weakness. A quarterly MDS (Minimum Data Set) assessment, dated 3/28/19, indicated the resident had behaviors of rejection of care 1-3 days during the assessment period and had an unstageable pressure ulcer wound that she received no treatment for. A quarterly MDS assessment, dated 6/27/19, indicated Resident V had no rejection of care behaviors, had an unstageable pressure ulcer wound, and received pressure ulcer treatments. An annual MDS assessment, dated 8/13/19, indicated the resident had a BIMS (Brief Interview Mental Status) score of 15 which signified she had no cognitive impairment. The resident had no refusal of care and no mood issues. She required extensive assistance from 2 staff members for bed mobility, transfers, and toileting and was non-ambulatory. The resident was always incontinent of bowel and bladder and had a Stage 4 pressure ulcer (Full-thickness skin and tissue		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by deficiency practice. No other resident will be affected. All Residents residing in the facility will have a head to toe assessment completed by a licensed nursing staff member by 9/26/19. Any resident noted to have a skin alteration and/or wound will have findings documented in their individual nurse's notes. Any resident noted to have a skin alteration and/or wound will have findings documented on the appropriate pressure/non-pressure skin tracking form. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The MD of any resident noted to have a skin alteration and/or wound will be notified and appropriate treatment order will be obtained. Any resident noted to have a skin alteration and/or wound will have findings and treatment order (if warranted) care-planned. The POA of any resident noted to have a skin alteration and/or wound will be notified of the findings and treatment plan (if warranted). All licensed facility staff will be educated over skin	

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	loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to her sacrum/coccyx area. A Care Plan, initiated on 2/19/19 and reviewed on 7/3/19, indicated the resident had episodes of refusing care such as showers. Interventions, dated 2/19/19 were to explain all care prior to and while providing assistance and explain the importance of care. A Care Plan, initiated on 9/26/18 and reviewed on 7/3/19, indicated the resident was at risk for impaired skin integrity related to advanced age, current pressure ulcer to the coccyx, decreased mobility, venous insufficiency, and incontinence. Interventions included, but were not limited to, treatments as ordered, weekly skin assessments as indicated, assist to turn and reposition at least every 2 hours, and check and change every 2 hours and prn (as needed). A Care Plan, initiated on 9/26/18 and reviewed on 7/3/19, indicated the resident had a pressure ulcer to the coccyx due to impaired mobility. The goal was the resident would have no signs or symptoms of infections. Interventions included, but were not limited to, evaluate the wound for size, depth, margins, peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, and gangrene and document progress in wound healing on an ongoing basis; notify the physician as indicated; and monitor/document/report to the physician prn for signs/symptoms of infection such as green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, and fever. A TAR (Treatment Administration Record) dated		management/wounds by a Wound Care Certified person. Any licensed personnel (agency) will be educated over skin management/wounds prior to their scheduled shift at the facility. Skin assessments and measurements of skin altercations/wounds will be conducted by the Regional Director of Operations (also a licensed nurse) and/or Director of Nursing weekly on-going. - **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; and** Skin sheets will be reviewed by interdisciplinary team during the facility daily meetings. Administrator and Director of Reginal Operations will review progress weekly to ensure accuracy and compliance. RDO will review each weekly pressure report. - **by what date the systemic changes for each deficiency will be completed.** Administrator or Designee will audit weekly for four weeks, bi-monthly for the following two months after, and monthly for the last three months. A report of progress will be forwarded to the QAPI committee for a minimum of 6 months.	

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June 2019 indicated an order for the resident's coccyx pressure ulcer was ordered on 2/16/19 and discontinued on 6/21/19. The order had been for moistened gauze with Vashe wash and pack to the coccyx and cover with mepilex per the wound NP (Nurse Practitioner) every day shift for wound care. The TAR indicated the resident refused the treatment on all days except for 6/4 and 6/7/19. The TAR was blank for 6/3, 6/5, and 6/21/19. There were no wound measurements or skin assessments of the resident's pressure ulcer on the TAR or preceding nurse progress notes.

There were no tracking records of the wound the facility made available for review.

A Nurse Note, dated 6/21/19 at 10:00 a.m., indicated the resident's wound care was discontinued as the resident refused her treatments.

A review of Resident V's behavior records dated June 2019 indicated she had one refusal of a shower, but no other refusal of care.

Resident V's record did not indicate the physician was aware the resident had refused wound treatment and there was no physician order found that discontinued the treatments. There were no wound measurements, wound or skin assessments, nor any further documentation in the nurses notes for the resident's pressure ulcer until 7/11/19.

An outside provider lab result, diagnoses, and physician order, dated 7/9/19 and reported on 7/10/19, indicated the resident had been seen by an NP and had been diagnosed with acute cystitis (bladder infection), prescribed antibiotics, and the staff instructed to change the resident's

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incontinent brief every 2 hours. Additionally, the NP ordered the resident's pressure ulcer to be washed with soap 2 times per day, patted dry, bacitracin (antibiotic ointment) applied and covered with a dressing. The dressing was to be changed daily in the morning for her coccyx wound. Nurse progress notes did not indicate the resident had gone out of the facility to an appointment with the NP nor was there any documentation about the resident's symptoms of bladder infection. There was no assessment completed of the resident's coccyx wound.

Nurse Progress notes indicated the following:

7/15/19 at 2:00 p.m., the dressing to the resident's wound was changed. The wound on her coccyx measured 1 cm (centimeter) by 0.7 cm and had a depth of 3.7 cm. The wound had serosanguinous (blood and fluid) drainage with a foul odor. The resident was scheduled to be seen at the wound clinic on 7/23/19. There was no documentation the physician had been notified.

7/17/19 at unknown time, the resident's wound dressing had been changed. The old dressing had serosanguinous drainage with a foul odor and the wound bed had exposed bone visible. The physician was not notified.

7/23/19 at 2:00 p.m., the resident had appeared upset as she was unable to go the wound clinic appointment scheduled on this day. The appointment was re-scheduled. There was no other documentation to indicate why the resident was unable to go to the wound clinic.

7/24/19 at 2:00 p.m., Resident V's wound dressing was changed. She was supposed to be seen by the wound NP but the NP had come to the facility

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	at lunch time and the resident wanted to stay up and eat her lunch. She was assisted to bed after the meal so the wound NP could look at her coccyx wound however, the wound NP had already exited the facility. The nurse note indicated the resident had an appointment at the wound clinic at the end of the month. There was no documentation to indicate the physician had been notified or attempts made to have the wound NP come back to the facility to assess the wound. A Medical NP progress note, dated 7/29/19 at unknown time, indicated the facility had requested the NP to look at a wound on Resident V's coccyx. The resident had been seen in December 2018 by a wound NP and at that time was ordered to have wet to dry dressings with Mepilex to cover it. She was going to see the wound clinic tomorrow (7/30/19) and the NP was there to order a dressing to cover the wound in the interim time. The note indicated the resident at times, would refuse dressing changes and getting up out of her chair. Physical exam indicated there was a decubitus on the resident's coccyx but there was no assessment of the wound, staging, or measurements documented. The plan was that the NP had spoken with the resident at length about the importance of repositioning in order to reduce/offset pressure. She was adamant at this time to not have her wound packed; therefore, an order was given for a Mepilex dressing to the coccyx wound and have the resident follow up the next day with the wound clinic for their recommendations. Nurse Progress notes did not indicate a Mepilex dressing was placed over the resident's wound on 7/29/19 and the order was not placed onto the July TAR.			

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	Wound clinic progress notes, dated 7/30/19 at 9:30 a.m., indicated Resident V was seen for an initial visit for evaluation and treatment of a non-healing ulcer of the sacrum. The wound was located on the resident's sacrum and measured 1.8 cm by 0.6 cm and had a depth of 3 cm. The wound was assessed to be a Stage 4 pressure ulcer with bone involvement. The wound was debrided (removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process). Post-debridement measurements were 2.0 cm by 0.7 cm with a depth of 3.2 cm. There was no tunneling (passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) noted. The sacral bone was exposed and it was biopsied. The ulcer was a result of pressure. Orders were given to wash the wound with mild soap and water and pat dry; apply Dakins solution to dry gauze and gently pack into the wound. Cover the wound with an abdominal pad and secure with tape. The dressing was to be changed 2 times daily and when soiled. The resident was to be scheduled for an MRI (x-ray) of the sacrum/coccyx as soon as possible to rule out infection in the bone and an appointment made to see an infectious disease specialist. She was to return to the clinic in 1 week for follow up. A nurse progress note, dated 7/30/19 at 4:00 p.m., indicated the resident had been scheduled for an MRI to the sacrum on 8/9/19. On 8/1/19 at 8:10 a.m., the treatment to the resident's coccyx wound was completed. There was a moderate amount of purulent drainage with an odor present on the old dressing. At 4:00 p.m., the wound clinic called the facility and orders were received for Flagyl (an antibiotic) Tablet- 500 mg (milligram) tablets; give 1 tablet by mouth 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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times per day for wound bacteria.

Nurse progress notes indicated on 8/3/19 at 3:45 p.m. and 8/4/19 at 1:00 p.m., the resident's dressings to her coccyx were changed and the old dressings noted to have moderate amounts of purulent drainage on them. The resident's wound had a foul odor. There was no documentation the physician had been notified of the foul odor.

Wound clinic progress notes, dated 8/6/19 at 12:21 p.m., indicated the resident was seen for follow up of her sacral pressure ulcer. The bone biopsy, completed on 7/30/19, indicated she had acute osteomyelitis (infection of the bone). She was on Flagyl, scheduled for an MRI on 8/9/19, and had an infectious disease specialist appointment on 8/22/19. The wound was larger and pre-debridement, measured 1.8 cm by 0.6 cm with a depth of 4 cm. There was no tunneling. Post-debridement measurements were 1.9 cm by 0.7 cm and depth of 4.1. Orders were given to wash the wound with mild soap and water and pat dry; apply Dakins solution to dry gauze and gently pack into the wound. "Please do not use more than one piece of gauze to pack into the wound to avoid further infection". Cover the wound with a Mepilex sacral border dressing and change 2 times daily and when soiled. She was to return to the clinic in 1 week for follow up.

A TAR for August 2019 indicated the order for the residents wound care was discontinued on 8/6/19. The TAR indicated the resident had not received dressing changes to her coccyx wound after 8/6/19 until an order, dated 8/14/19 was put onto the TAR. The order, dated 8/14/19, was for the wound to be washed with mild soap and water and pat dry; apply Dakins solution to dry gauze and gently pack into the wound. "DO NOT" use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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more than one piece of gauze to pack into the wound to avoid further infection. Cover the wound with a Mepilex sacral border dressing and change 2 times daily and when soiled. The TAR was not initialed by the nurse, which indicated the treatment had been completed, on 8/14, 8/15, or 8/16/19 at 8:00 a.m.

A nurse progress note, dated 8/9/19 at 3:30 p.m., indicated treatment to the wound had been completed as ordered and the wound had purulent drainage. The note did not indicate what treatment had been completed on the resident's wound and there was no current order on the TAR.

Nurse notes from 8/9/19 did not indicate the resident had gone out to her MRI appointment which had been scheduled for this day. The results of the MRI were not found in the written nor electronic medical record.

Nurse progress notes indicated the following:

8/12/19 at 12:55 p.m., transportation was unable to take the resident to her wound clinic appointment on 8/13/19 and was re-scheduled for 8/20/19.

8/17/19 at 10:00 p.m., the resident's wound dressing was changed. The wound had green drainage with an odor. There was no documentation the physician had been notified of the change in the character of the exudate.

8/18/19 at 7:00 a.m. and 10:00 p.m., the resident's wound had moderate amounts of purulent drainage with a foul odor. There was no documentation that the physician was notified of the change in color of the resident's wound drainage or foul odor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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Wound clinic progress notes, dated 8/20/19, indicated the MRI of her sacrum on 8/9/19 showed a 3.5 cm abscess and osteomyelitis of the distal sacrum and coccyx. Resident V had an infectious disease appointment scheduled for 8/22/19 and the plan was to schedule an orthopedic appointment as well. Her wound was larger; pre-debridement, the wound measured 2.1 cm by 0.7 cm with a depth of 4 cm. There was no tunneling. Post-debridement measurements were 2.2 cm by 0.8 cm and depth of 4.1. The wound required further debridement. The resident's wound treatment remained the same: wash the wound with mild soap and water and pat dry; apply Dakins solution to dry gauze and gently pack into the wound. The wound clinic progress notes indicated -Please do not use more than one piece of gauze to pack into the wound to avoid further infection. Cover the wound with a Mepilex sacral border dressing and change 2 times daily and when soiled. The physician order stated "Do not use small pieces of gauze to pack wound. Only use one solid piece of Kerlix. Order more Dakins solution". She was to return to the clinic in 1 week for follow up.

The August 2019 TAR indicated the residents wound treatment was not completed on 8/23 and 8/26/19 at 8:00 p.m. The TAR referred to the nurse progress notes for an explanation of why the treatments were not completed. Nurse progress notes for 8/23 and 8/26/19 did not indicate why the resident's wound treatments were not completed.

Wound clinic progress notes, dated 8/27/19 at 7:34 a.m., indicated the visit was a follow up. The resident had her appointment with the infectious disease specialist on 8/22/19 and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	recommended IV antibiotics but she had refused. The wound was the same size as the week before-2.1 cm by 0.7 cm with a depth of 4 cm. There was no tunneling. Post-debridement wound measurements were 2.1 cm by 0.7 cm with a depth of 4.2. Wound treatment orders were to wash the ulcer with mild soap and water, then pat dry; moisten gauze with 1/4 strength Dakins solution and gently pack into ulcer and cover with abdominal pad; change 2 times per day and prn soiling. The physician order stated "DO NOT PLACE MULTIPLE GAUZE PIECES IN ULCER. USE 1 PIECE OF KERLIX GAUZE. YOU ARE PUTTING THE PATIENT AT RISK FOR INFECTION AND SEPSIS. WE REMOVED 4 PIECES OF OLD GAUZE FROM ULCER TODAY". Handwritten below this was "Kerlix-NOT 4x4's!!" The August 2019 TAR indicated the resident's wound treatment was not done, as ordered, at 8:00 p.m. on 8/27, 8/29, 8/30, or 8/31/19. Nurse Progress notes from 8/27-9/3/19 indicated the resident continued to have purulent drainage with foul odor from her wound and gauze dressings. There was no documentation to indicate the physician was aware of the status of the wound. On 9/3/19 at 2:00 p.m., a nurse progress note indicated the resident had gone to the wound clinic for her scheduled appointment. The wound clinic nurse had called the facility and reported the resident's wound had deteriorated and had several tunneling areas in the wound as well as a very foul odor. The resident was being sent to the ER for treatment. The clinic nurse requested the last 6 weeks of the wound clinic's care reports sent to the facility, be faxed to the wound clinic.			

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	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	Wound clinic progress/care reports were not found in the resident's medical record. The facility's medical records coordinator requested the reports from the wound clinic which were then provided on 9/24/19 at 11:36 a.m. Results of the MRI completed on 8/9/19 was faxed to the facility on 9/24/19 after requested. The MRI report indicated the following: The resident had a pressure ulcer with an underlying abscess and osteomyelitis of the distal sacrum and coccyx. The wound clinic progress note for 9/3/19 at 7:38 a.m., indicated the resident's wound now tunneled circumferentially (in a way that encircles-around the center). There was purulent drainage and a foul smelling odor. The resident was referred to orthopedic surgery and colorectal surgery but the physicians refused to see the patient. The patient needed surgical debridement and IV antibiotics in order to adequately heal the wound. She will be sent to the ER for definitive treatment. The wound measurements were 1.5 cm by 0.5 cm and a depth of 3 cm. Tunneling-reported as positions on a clock were: at 12 o'clock position, tunneling was at 6.4 cm; at the 4 o'clock position, tunneling was at 6 cm; at the 6 o'clock position, tunneling was at 3.5 cm; and at the 9 o'clock position, tunneling was at a depth of 5 cm. During a confidential interview, Employee 2 reported inadequate nurse staffing at the facility and concern that residents were not receiving medications and treatments as ordered because there was no staff to do them. On 9/20/19 at 11:51 A.M., the interim DON (Director of Nursing) was interviewed. During the interview, she indicated residents were not receiving treatments as ordered because of			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	inadequate staffing. She indicated Resident V had not been provided care as ordered by the physician. The wound care physician notified her that nurses were packing the resident's wound on her coccyx with too much gauze and were not removing the soiled gauze from her wound when changing the dressing. She alleged the physician indicated staff at the wound clinic had to "keep picking it (gauze) out of the wound" and had found "several pieces of rotten gauze" in the resident's wound. The resident was hospitalized on 9/3/19 due to her pressure ulcer worsening in size and infection in the wound. The DON indicated she re-educated the nursing staff on how to pack the resident's wound with kerlix instead of 4x4 gauze. She did not provide documentation of the re-education given to nurses. On 9/23/19 at 1:51 P.M., during an interview with the Administrator, she indicated she had been told the resident would often refuse her treatments in addition to refusing to lay down for pressure relief to her coccyx. The administrator indicated she had not been in charge of the facility on 6/21/19 when the resident's wound treatment had been discontinued. The nurse that discontinued the wound treatment on that day was currently on medical leave and unable to be interviewed. The Director of Nursing during that time period was no longer employed by the facility and was unavailable for interview. Nursing staff, currently working in the facility, were agency staff who had no knowledge of the resident's wound as she was now discharged from the facility. The Interim DON, interviewed on 9/20/19, was not available for further questioning. On 9/24/19 at 12:23 p.m., LPN 3 (Licensed Practical Nurse) was interviewed. During the interview, she			

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	155763	A. BUILDING 00 B. WING	09/27/2019

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	expressed much distress that the facility was so inadequately staffed and that resident care could not be completed due to lack of staff. On 9/24/19 at 1:00 P.M., the SSD (Social Service Director) provided copies of Resident V's Behavior Management Records dated June, July, and August 2019. The SSD indicated the resident was monitored and behaviors tracked for refusal of care, refusing showers, arguing with staff, and attention seeking. Behavior Management Record dated June 2019, indicated the resident had one refusal for the month-she refused a bed bath on 6/7/19. Behavior Management Record dated July, indicated the resident refused care and was attention seeking on 7/19, 7/20, and 7/24/19. The reason documented for the behavior was as follows: the resident was demanding more care above other resident's needs. Behavior Management Record dated August and September 2019, indicated the resident had no refusals of care. On 9/24/19 at 11:54 A.M., the Administrator provided a current copy of the facility's policy titled "Skin Management" which stated the following: "Resident with skin impairments will have: appropriate interventions implemented to promote healing, a physician order for treatment, wound location and characteristics documented in the nursing notes...In addition, the following forms are completed and placed with the resident's Treatment Record: Pressure Ulcer: Weekly Pressure Ulcer Record...A Care Plan is developed upon admission, identifying the contributing risks for breakdown, including history of skin impairment or the actual impairment, and the interventions implemented to promote healing and prevent further breakdown...Wounds are tracked			

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	155763	A. BUILDING 00 B. WING	09/27/2019

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	as acquired...and are assessed and documented on the Weekly Pressure Ulcer Record. These records are maintained in the resident's Treatment Record while in use. The Licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record (TAR). A Physician's order will be written to monitor each ulcer and documentation on the TAR will reflect the status of the dressing, surrounding skin color and skin and pain associated with the wound...The Licensed Nurse will record his/her initials on the TAR to reflect the monitoring of each wound regardless of the findings...The nurse will assure treatments, interventions, Care Plan, and the appropriate skin documentation records are initiated in a timely manner according to Practice Guidelines. Pressure ulcers are measured and staged weekly in accordance with the Practice Guidelines...Residents who are at risk or with wounds and/or pressure ulcers...are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes...." The immediate jeopardy that began on 6/21/19 was removed on 9/27/19 when the facility performed skin assessments on all residents in the facility, documented findings in the nurse notes, notified physicians of skin alterations/wounds and obtained treatment orders, and provided skin and wound management education to licensed nurses by a Wound Care Certified Practitioner. Non-compliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all physicians or families had been notified of new skin alterations/wounds and care plans had not been completely updated.			

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	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	This Federal tag relates to Complaint IN00306026. 3.1-40(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse served as the Director of Nursing on a full-time basis and failed to ensure a Registered Nurse was in the facility at least 8 consecutive hours a day, 7 days a week. This deficit practice had the potential to affect 42 of 42 residents that resided in the skilled nursing facility. Findings include: On 9/20/19 at 11:51 A.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated she was the Interim DON. She served part-time as the DON due to her schedule and that she was in the facility as much as she was able to be. She had given a resignation letter	F 0727	***F727*** RN 8 hrs/7 days a week, Full Time DON - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator and/or Designee will continue to focus on hiring staff with a strong focus directed to Nursing Leadership and the nursing Department to ensure compliance. - **how other residents having the potential to be affected by the same deficient**	10/27/2019

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	to the Administrator which indicated effective September 16, 2019, she was resigning her position as the Interim DON but would continue to work as needed on the floor as a charge nurse when her schedule permitted. She indicated, to her knowledge, the Administrator had not removed her as the Interim DON. She indicated when she agreed to be the Interim DON, it was with the understanding that she could not serve in a full time capacity which had been acceptable to the Administration. On 9/24/19 at 11:54 A.M., the Administrator was interviewed. During the interview, she indicated she was aware of the regulation that required the facility to have an RN (Registered Nurse) serve in a full-time capacity as the DON. She indicated she and the company had made numerous attempts and continue to try to obtain a full-time RN to serve as the facility's Director of Nursing. She indicated there had recently been a large turnover in the nurse staffing and they were working with agency nurses. The facility was not able to provide the services of a Registered Nurse for 8 consecutive hours a day, 7 days per week. The facility did have licensed nurse staff scheduled and hours worked every shift, 24 hours per day, 7 days per week. The Interim DON's time card report, provided by the HR Director on 9/24/19 at 12:06 P.M., indicated the DON, who was an hourly employee, worked the following weeks and hours as the Director of Nursing: 7/1-7/7/19-19 hours 7/8-7/14/19-34.25 hours 7/15-7/21/19-20 hours 7/22-8/4/19-0 hours 8/5-8/11/19-0 hours		**practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by alleged deficient practice. No other resident will be affected. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator or Designee will ensure prompt follow-up with all applicants. All new hires will receive proper training of job description and policies and procedures. Facility is no longer in need of Agency C.N.A.s and will continue the same process to illuminate the need of Agency Nurses. - **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; and** Administrator or Designee and interdisciplinary team will meet weekly for four weeks, bi-monthly for the following two months after, and monthly for the last three months. A report of progress will be forwarded to the QAPI committee for a minimum of 6 months. **by what date the systemic changes for each deficiency will be completed.** New Full	

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	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	8/12-8/18/19-16 hours 8/19-8/25/19-15 hours 8/26-9/1/19-25.5 hours 9/2-9/8/19-0 hours 9/9-9/16/19-5.25 hours. Review of the daily as-worked nursing schedule from 9/1-9/20/19 indicated the facility did not have an RN for 8 consecutive hours worked for the following days: 9/1, 9/2, and 9/7/19. This Federal tag relates to Complaint IN00306026. 3.1-17(b)(4)		time Interim Director of Nursing went into effect on September 20th, 2019. Jean K, R.N., will fulfill that role until a permeant Director of nursing is found.	
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility 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 implement effective behavioral interventions to prevent untoward behaviors for 1 of 3 residents reviewed (Resident S). The deficit practice resulted in the 3 of 3 residents feeling intimidated and fearful for their safety (Resident T, Resident X, and Resident Y). Further, the facility failed to comprehensively assess and implement effective behavioral interventions prior to increasing psychoactive medication for 1 of 1 residents (Resident R).	F 0740	Behavioral Health - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility will closely monitor Resident S. in all social situations while locating more appropriate placement. - **how other residents**	10/27/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	Findings include: 1. On 9/20/19 at 1:46 P.M., Resident S's record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury, stroke, psychotic disorder with delusions, bipolar disorder, impulse disorder, and other sexual disorders. The resident was currently hospitalized at a psychiatric facility but was expected to return to the facility following hospital discharge. A Pre-Admission Screening and Resident Review (PASRR) level I, dated 8/19/19, indicated the resident had the following behaviors and symptoms: serious difficulty interacting with others, physical threats, and excessive irritability. He was referred for a level II assessment. A Pre-Admission Screening and Resident Review level II, dated 8/27/19, indicated the following: the resident was able to communicate his needs to others; he had behavioral issues at the previous nursing facility; He expressed feelings of depression and anxiety; cited that "old people" going into his room was a trigger for his anxiety; coped with stressful feelings by "mentally" removing himself from the situation; had no safety or risk concerns; enjoyed playing X-box, looking at pictures of his children, and watching Netflix. Services that would need to be provided to the resident included, but were not limited to, a person centered safety plan specifically designed to assist him with maintaining socially appropriate behaviors while in the nursing facility, psychiatric counseling services, and medication management/monitoring to ensure he took his medications and they were effective. An admission MDS (Minimum Data Set)		**having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by alleged deficient practice. No other resident will be affected. The facility will 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. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Facility will re-educate staff on behavior monitoring and documentation. Resident S was evaluated, and medication re-evaluated. Comprehensive assessments and plan of care for all affected will be reviewed and updated. - **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; and** Administrator or designee will monitor Mood Changes and Behaviors daily at morning department meeting that occurs	

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	assessment, dated 7/18/19, indicated the resident had a BIMS (Brief Interview Mental Status) score of 15 which signified he had no cognitive impairment. The resident had no behaviors or mood indicators. He required supervision and limited physical assistance while propelling himself in the hallways. Care Plans for behaviors and use of psychoactive medications were as follows: 7/11/19-Resident S is a Level II per PASRR and did not require specialized services; his medical needs took precedence over other services. Interventions included, but were not limited to, refer to psychiatric services for continued mental health services, medication review, monitoring, administration, and adjustment. 7/28/19-Resident S required use of psychoactive medications related to psychiatric diagnoses. Interventions included, but were not limited to, assess for side effects and complications, if behavioral symptoms are observed; record and document daily in the behavior log; report untoward effects and abnormalities to the physician, and offer behavioral counseling and intervention to help the resident cope with mood and/or behavioral distress and dysfunction; teach the resident coping strategies to enable him to compensate for delusions. 8/5/19-The resident had behaviors of yelling at other residents when provoked. The goal was the resident would not yell at other residents. Interventions were to explain to the resident that his behaviors were not appropriate, redirect him, and refer to psychiatric services. Behavior Management Records indicated		Monday thru Friday. Administrator or Designee to be contacted on Saturdays and Sundays to address any immediate concerns. Interdisciplinary team will review of the weekend Mood Changes and Behaviors. If changes are needed, Care plans will be updated and followed. - **by what date the systemic changes for each deficiency will be completed** by Administrator or Designee will audit weekly for four weeks, bi-monthly for the following two months after, and monthly for the last three months. A report of progress will be forwarded to the QAPI committee for a minimum of 6 months.	

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	155763	A. BUILDING 00 B. WING	09/27/2019

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behaviors towards other residents were the following:

August 2019-
8/4/19 at 4:15 p.m., the resident had verbal aggression at another resident. Interventions were to remove him from the situation, provide 1:1 and allow to speak about what caused the behavior and offer reassurance and validate feelings.

8/7/19 at 10:00 a.m., Resident S had an argument with another resident. Interventions were to remove him from the situation, provide 1:1 and allow to speak about what caused the behavior and offer reassurance and validate feelings.

There were no Behavior Management Records provided for September 2019.

On 9/20/19 at 1:20 P.M., Resident T, identified as interviewable by the facility, asked to be interviewed. The resident was observed in her room seated on her bed. She had a tracheostomy tube and was not able to speak loudly but talked in a loud whisper. She indicated, emphatically, she didn't want that man to ever come back to the facility because she was afraid of him. When questioned, she indicated the man was Resident S. The resident indicated "He's not here now" and she doesn't know where he went but repeated she didn't want him to come back. She was clearly distressed and her whisper became louder and more pressured as she used her hands to illustrate where the resident's room was across the hall from hers. Her eyes became wider, she frowned and her breathing increased as she spoke. Resident T indicated she had to have the staff keep the door to her room closed when he had been here because he would come into her room. She

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	indicated the resident was very large and sat in a wheelchair (w/c) and moved himself backwards in it. She described an incident that occurred where Resident T had backed into her while in his w/c when he was rapidly moving down the hallway. She was knocked down and fell against the handrail. She indicated Resident S told her to "get out of his way". She indicated she reported it to the nurse and had gotten a bruise on her hip from the fall. She stated Resident S was mean to her, other residents, staff, and his mother. He sat at the nurses station talking on the phone and would yell and curse on the phone. Nurses would ask him to stop but he would ignore them and keep yelling. She spoke of another incident where Resident S made fun of her because of her tracheostomy. It had upset and embarrassed her in front of a group of other residents who had been sitting outside together. She reported this to staff. Resident T then repeated again, she hoped Resident S didn't come back to the facility. On 9/20/19 at 1:31 P.M., Resident X, identified as interviewable by the facility, was interviewed. She was observed to have a stop sign cloth barrier across the entrance to her room. She indicated she was afraid of Resident S because he ran into others with his w/c. She indicated Resident S was mean, nasty and yelled at everyone around him. She indicated she had not shared her concerns with staff because she knew other residents had. On 9/23/19 at 10:48 A.M., Resident Y, identified as interviewable by the facility, was interviewed. When questioned if she'd had any concerns with staff or other residents, she immediately asked "Resident S is not coming back here? Do you know?". She stated tearfully she was afraid of him! She indicated the resident was Resident S who was a big guy who used a w/c to get around			

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	155763	A. BUILDING 00 B. WING	09/27/2019

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the facility. "He moves his w/c backwards and runs into people"! She indicated the resident would sit in the hallway, in front of her doorway and block her from going in and out of her room. He blocked the door to the facility so her family couldn't come in. She indicated Resident S's family member had been a short term resident at the facility awhile back, the family member's room had been across the hallway from her room and he would go often into the family members room. She indicated she overheard the resident yelling and cursing at his family member often when he went to their room. Resident S would yell and curse at other residents, staff, and his family member. She kept reporting this to nurses and CNA's (Certified Nurse Assistants) but "found out" she had been telling the wrong people. She was supposed to share her concerns with the SSD (Social Service Director) but when she went to her office, she was never present. Resident Y indicated she assumed staff communicated with each other and believed staff should have conveyed her concerns. She again, wanted to know if the resident was coming back to the facility and stated she was very fearful!

Resident S's Nurse Notes and Social Service Notes indicated the following:

7/19/19 at 11:10 a.m., the resident was on the phone (at the nurse station) where he kept backing into other residents while on the phone. He was asked to stop but he continued.

7/27/19 at 11:20 a.m., the resident had several behaviors towards staff. He was up in his w/c and propelling himself backwards and would run into "objects". He would tell the "objects" to get out of his way.

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	8/4/19 at 4:15 p.m., Resident S threatened to hit another resident. When asked why, he indicated the resident called him a "wide load". The resident was shouting, name calling, and using profanity. He was removed from the situation and allowed to vent his frustrations. The 2 residents were kept separated for the evening. 8/5/19 at 9:52 a.m., a Social Service Note indicated the resident had threatened to hit another resident on 8/4/19. The care plan was updated to indicate Resident S could have verbal aggression when provoked by other residents. If this occurred, staff were to tell the resident his behaviors were inappropriate, re-direct him, and refer to psychiatric services. 8/14/19 at 1:04 p.m., a Social Service Note indicated the resident's behaviors occurred more in the evenings when there were no activities. There was no documentation or update made to the care plan or Behavior Management Records to provide activities in the evenings to decrease the residents behaviors. 8/27/19 at 8:40 a.m., a Social Service Note indicated Resident S had behaviors such as making false accusations against other residents, using other residents computer to get on the internet, and inappropriate sexual behaviors towards staff. The resident was spoken to by the SSD and Administrator about these behaviors and the resident told the behaviors would not be tolerated at the facility if his actions and behaviors affected other residents and their well being. The care plan was updated. A Nurse Note for Resident T, dated 8/27/19 at 9:50 p.m., indicated Resident S had been propelling his w/c backwards in the hallway and bumped into			

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	Resident T pushing her into the handrail. She complained of back and side pain but had no redness, bruising, or swelling. There was no documentation completed in Resident S's nurse notes, Social Services notes or Behavior Management Record to indicate the event had occurred and what interventions were put into place to prevent this from occurring again or how staff were to protect other residents. 8/30/19 at 3:31 p.m., a Social Service Note indicated the resident's guardian had been contacted and notified of the resident's behaviors which had been increasing daily. On this date, Resident S was observed seated at the nurses station using the phone to talk with his guardian. In the presence of other residents, he was heard yelling on the phone and told his guardian he wished she were dead. The resident was spoken to daily about his behaviors including his disruptive behaviors in front of other residents at the facility. His care plan was updated. 9/6/19 at 1:45 p.m., a Social Service Note indicated the SSD had been notified by another resident (Resident Y) that Resident S had been sitting outside her room and not moving when being asked to and was in the activity room on this day, blocking the doorway. When he was asked to move, he became verbally aggressive. Resident Y's family also reported the resident had blocked the doorway to the facility and had not let the resident's family in the building. The resident's guardian was notified of the behaviors and a referral made to an in-patient psychiatric hospital. 9/6/19 at 3:45 p.m., Resident S was outside smoking with a group of other residents. A fellow resident (Resident T) complained of being made fun of by the resident and she was crying and			

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	155763	A. BUILDING 00 B. WING	09/27/2019

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	upset. The SSD was notified who went outside to speak with the resident about his ridiculing another resident. 9/7/19 at 2:45 p.m., Resident S was transported by EMS to the psychiatric hospital. On 9/24/19 at 3:08 P.M., the SSD was interviewed. During the interview, she indicated Resident S had been seen for psychiatric services including the psychiatric NP and counselor. When questioned about false accusations the resident made about another resident, she indicated Resident S had accused another resident of having drugs and was going to call the police on them. The resident had many behaviors towards female staff members and his behavior management plan focused on managing these behaviors so he could be provided care. The SSD indicated she tried to spend 1:1 time with the resident often to keep him occupied and away from female staff and other residents. She had been trying, unsuccessfully, to assist the resident to find another facility where there were younger residents and one which could manage his behaviors effectively. Psychology and Psychiatric Progress Notes indicated the resident was seen on 7/23, 7/25, 8/6, 8/8, and 9/6/19. The focus of the progress notes was on the residents behaviors towards staff members and not the resident's behaviors towards other residents. A Psychology Progress Note, dated 8/6/19 at unknown time, indicated Resident S had a recent incident with a female peer who referred to him negatively about his weight. This reportedly led to conflict with that peer. Discussed with resident effective communication strategies, instead of			

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engaging verbal aggression. These communication strategies were not found on the care plan nor were staff educated on how to assist the resident to use these strategies to prevent verbal aggression against other residents.

A Psychiatric General Note, dated 8/29/19 at unknown time, indicate the NP had been notified of the resident's increased behaviors. The note did not indicate if the behaviors were towards other residents or with staff. The NP ordered Ativan (anti-anxiety medication) 1 mg (milligram) every 6 hours as needed. The NP indicated she would be at the facility in 14 days to assess the resident.

A Psychology Progress Note, dated 9/6/19 at unknown time, indicated the resident continued with intrusive behaviors. He recently called family members of other resident, telling the family members that proper care was not given to the other resident. He continued to display vulgar behaviors around other residents. In addition, it had just come to the attention of staff that the resident had been harassing another female resident by sitting in his w/c outside her room and giving her dirty looks. He reportedly had been often keeping the resident from leaving and entering her room and from coming back into the facility. This reportedly had been quite stressful to the female resident and she nearly phoned the police recently to address this matter.

2. On 9/20/19 at 12:31 P.M., Resident R's record was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety disorder, depression, and insomnia.

A quarterly MDS (Minimum Data Set)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	assessment, dated 8/23/19, indicated the resident had a BIMS (Brief Interview Mental Status) score of 4 which signified she had severely impaired cognition. The resident complained of feeling down, depressed, or hopeless 1 day during the assessment and had no behaviors. She propelled her w/c (wheelchair) in the hallway with supervision and limited assistance. Resident R indicated she had occasional pain that made it hard to sleep at night and limited her day to day activities. Care Plans related to behaviors indicated the following: 4/29/19-Resident R had a diagnosis of anxiety. The goal was the resident would openly express anxiety as needed and encouraged by the SSD (Social Service Director). Interventions were to be aware of how much information the resident could deal with, encourage verbalization and expression of feelings, and provide information to calm. 4/29/19-the resident was at risk for side effects related to the use of psychotropic medication. The goal was she would have no side effects related to the use of psychotropic medication. Interventions were to give medication as per physician order, observe for side effects: increased confusion, restlessness, sedation, headache, dizziness, appetite change, increased agitation, itching, etc and report any noted side effects. 4/29/19-Resident R had a diagnosis of depression. The goal was she would have no signs/symptoms of depression. Interventions were to encourage out of room activities, medication per physician orders, and observe for signs/symptoms of depression such as tearfulness, withdrawn, loss			

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of appetite and document all episodes; inform SSD of episodes.

5/2/19-the resident had difficulty falling asleep at night due to insomnia. The goal was the resident would state she felt rested and will have no complaints of inability to fall/stay asleep. Interventions were to encourage activities/exercise during daytime hours, encourage her to limit daytime naps, medications as ordered, minimize background light/noise at night, monitor for adverse effects of medications and notify the physician, offer a backrub, and provide an evening snack as needed or requested.

5/6/19-the resident was on the call light often. The goal was the resident would voice satisfaction of her wants and needs being met. Interventions were to anticipate her wants and needs and encourage her to use her call light when she truly had a need.

On 9/20/19 at 12:12 P.M., Resident R was observed seated in the dining room in her w/c at a table with 2 other tablemate's. She appeared frail and thin. Her speech was clear and she indicated she wanted to call her daughter to come get her as she wanted to go home. She was cordial to her tablemate's but kept repeating she wanted to go home. She appeared anxious and she kept folding and unfolding a piece of paper with phone numbers on it between her fingers. She was observed to run her hands through her hair several times. She indicated she didn't want to eat because she wanted to go home.

On 9/24/19 at 2:55 P.M., Resident R was observed seated in her w/c next to the nurses station. Her speech was slurred and slow as well as her movements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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On 9/25/19 at 1:50 P.M., the resident was observed seated in her w/c in the lobby. A family member was present and holding her hand. She was observed to be calm but her speech remained slow and slurred.

Admission physician orders, dated 4/27/19 at unknown time, included, but were not limited to: Xanax (anti-anxiety) 0.25 mg (milligrams) 1 tablet by mouth one time a day for anxiety disorder.

Nurse Notes from May 2019 indicated the following:

5/2/19 (Thursday) The resident at times, on this day, would become upset that family were not present and taking care of her. She transferred herself, unsupervised, a couple of times. She had no complaints of pain.

5/7/19 (Thursday) at 10:35 a.m., after breakfast, the resident approached the nurse and was crying and stated "Oh please, can't you give me something to calm me down so I can rest"? Staff called and left a message for family that she wanted to see her grandson and her dog. Staff would notify the SSD about having the resident be seen by psychiatric services to review her medications.

5/26/19 from 2-6 p.m., Resident R had increased confusion. She was exit seeking, wanting to go home and she wanted someone to call the police. She was very anxious. The residents family member came to visit and she stated the resident would do this often and wouldn't remember it tomorrow.

5/27/19 at 7:00 p.m., the resident had increased

anxiety/agitation on this shift. Staff attempted to re-direct her.

5/31/19 on "second shift" the resident had increased anxiety. She stated "please give me something to make me sleep". She wanted to call her family. Staff called and left messages for the resident's family members. She was observed to propel herself to her room where she turned her w/c alarm off and stood up. The NP called and gave a new order.

6/1/19 at unknown time, a physician order was for Xanax 0.25 mg give 1 tablet 3 times a day related to anxiety.

6/29/19 at 11:00 a.m., the resident was ambulating per self in her w/c. She was anxious about items lost and nothing to do. She would not rest when lying down and would get right back up from bed.

7/4/19 (Thursday) at 10:00 a.m., Resident R was very anxious. She didn't understand why she was there and had asked staff why they wouldn't help her. She had been assisted to toilet several times. The resident kept transferring herself from bed to chair and vice versa. She was not happy with any suggestions staff made and requested to call her family member. The note indicated the family member asked not to be bothered. The resident kept asking for something to help her sleep. The resident took Xanax 0.25 mg 3 times per day but it was not working. Staff would continue to monitor.

7/17/19 at 10:30 a.m., Resident R was "clearly upset". She indicated someone had "snatched" her out of bed and painted her finger nails an "ugly color". She indicated she thought they should've asked her first and wants the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	spoken to. She indicated she was going back to bed. 7/18/19 at 10:00 a.m., when the nurse arrived to the floor, the resident came to the nurses station and was very agitated. She complained that her hair looked bad because "the lady had too many people in there" and she didn't think she did a good job on her hair and thought it looked "awful". The resident was given assurance but she continued to cry because there were too many people in there (beauty shop). She was assisted back to her room to lie down for a nap. 7/26/19 at 2:10 p.m., the resident was crying and asked everyone that passed by her to "please help" her. She would not say what was wrong but kept repeating for someone to help her. A Physician Progress Note, dated 7/26/19 at unknown time, indicated the resident had complained of left ear pain. She had an open ulcer on the left pinna (visible part of ear) that was probable skin cancer. A referral was to be made to a dermatologist. The physician did not document the resident had been in any distress, had behaviors daily, or that she had been anxious and asking everyone to help her. 8/1/19 at 10:00 p.m., a Nurse Note indicated the resident had been very anxious, had yelled out and tried to transfer herself. 8/7/19 at 1:45 p.m., the resident had been transferring herself from w/c to bed constantly throughout the day and would become angry when staff attempted to redirect her. She demanded staff call her family and indicated she didn't understand why they didn't visit her and she had just been "dumped here" and			

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"forgotten".

A Behavior Management Record, dated 8/11/19 at unknown time, indicated the resident had behaviors of yelling out and wanting to go home. The reason for the behavior was she was anxious and bored.

8/15/19 at 10:40 a.m., a Nurse Note indicated the resident had been sleeping through breakfast.

8/20/19 at 10:30 a.m., Resident R appeared to be having a difficult day. She approached the nurse several times and indicated people were talking about her. She was difficult to redirect and exhibited paranoid behaviors and was accusatory to all she came into contact with. She appeared sad. There was no documentation to indicate the physician or family were notified of her paranoid behaviors.

A Behavior Management Record, dated 8/28/19 at unknown time, indicated the resident had behaviors of wanting to go home and call family. The reason for the behavior was she was bored.

9/10/19 at 9:45 p.m., a Nurse Note indicated the resident set off her chair and bed alarm multiple times through the shift. She transferred herself from bed to chair or would sit up on the side of the bed.

9/17/19 at 2:00 p.m., Resident R was weepy and stated she wanted to go home with her family. She was provided assistance with trying to call her family but there was no answer. Messages were left for family to call the facility.

Social Service Notes indicated the following:

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	5/9/19 at 11:04 a.m., the SSD spoke with the resident's family regarding the need for psychiatric services. The family indicated they would like to wait for Medicaid to be approved first. The family was notified of the resident's increased anxiety and that staff would be contacting the physician to increase the resident's Xanax in the evening when she had increased anxiety. 9/17/19 at 3:24 p.m., the resident has had increased agitation wanting to call her family and wanting to go home. Her family was called and there was no answer so a message was left for the family member to call the facility back. While waiting to hear from the family, the resident went into the dining room and was asking a nurse to call her daughter. The nurse immediately became upset and according to witnesses, the nurse put her hands on the resident and moved her out of the dining room. Staff intervened and the resident was removed from the area. Family was called and a message left to contact the facility. 9/17/19 at 3:33 p.m., the resident was upset and stated she wished she was dead. She repeated this multiple times. She was put on 1:1 observation and would be checked every 15 minutes. The resident would be referred to psychiatric services and her care plan updated. 9/19/19 at 3:06 p.m., Resident R was placed onto psychiatric services and had medication changes. 9/20/19 at 11:05 a.m., the resident had experienced these behaviors previously and were not new however, the behaviors were becoming more regular. She was referred to psychiatric services. On 9/23/19 at 1:45 P.M., the SSD was interviewed			

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	about Resident R's behaviors and referral to psychiatric services. She indicated the resident was referred on 9/18/19 and new orders received on 9/19/19 to increase the resident's anti-anxiety medications and start and anti-depressant medication. A copy of the referral and psychiatric progress note was requested. On 9/23/19 at 4:01 P.M., the SSD provided a copy of a General Note, dated 9/23/19 at unknown time which indicated the facility had called the their contracted psychiatric services. The note indicated Resident R's behaviors were reviewed for 9/20/19 and that the resident had been observed at last visit with increased tearfulness and thoughts of just simply giving up; psych services were referred and the writer (NP) was waiting for paperwork to be processed before leaving the facility. The note indicated the resident had a history, per family, of repeating that she would rather be dead but had never attempted to act upon the statement nor devised a plan. The resident's history was significant for depression and anxiety. The NP reviewed the residents medications and behavioral notes per the SSD and nursing and called back the facility with the following orders 9/20/19: start Sertraline (anti-depressant) 50 mg (milligrams) by mouth daily for 1 week then increase to Sertraline 100 mg by mouth daily thereafter for severe depressive disorder. Start Xanax 0.5 mg by mouth 3 times per day for the resident's long history of anxiety. The facility was to contact the psychiatric NP if the resident required additional medication adjustments due to mood or behavioral disturbances. The facility was to continue the current treatment plan and psych services as provided would follow up at the next visit. The SSD indicated the resident had not yet been seen by the psychiatric NP nor had she been on			

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	psychiatric services prior to 9/20/19. On 9/24/19 at 12:23 p.m., Nurse 7 was interviewed. During the interview, she indicated the psychiatric NP had been contacted on 9/19/19 by the SSD who provided information about the resident's behaviors. Nurse 7 indicated she was then asked to speak with the psychiatric NP so she could receive orders which were to increase the residents Xanax dosage and start an anti-depressant medication. On 9/25/19 at 11:40 A.M., the SSD provided a current copy of the facility policy titled "Behavior Management Policy" which stated the following: "Our goal is to provide a safe and secure environment with interdisciplinary involvement for all residents exhibiting psychosocial and physical well-being concerns. This program will provide the staff with guidelines by which they can plan, intervene, control, and prevent harmful behaviors. Resident's with behaviors that are problematic and/or dangerous for themselves or others will be identified. A behavior management plan will be developed based on the resident's needs and implemented...Behavior monitoring tracking forms will be reviewed monthly...as a way to determine which interventions are effective in managing the residents behaviors. Facility will identify proactive interventions in an attempt to prevent negative behaviors. The behaviors documented on these forms should include the date and time of the specific behavior, the specific behavior, frequency, a brief description of what occurred prior to the behavior, interventions attempted, effectiveness of interventions attempted and the signature of the person witnessing the behavior(s)...." This Federal tag relates to Complaint IN00306915.			

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	3.1-37			