	R MEDICARE & MEDIC				OMB NO. 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155230	A. BUILDING B. WING	00		
			STREET	TADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		CHESTER BLVD		
ROSEBU	JD VILLAGE			MOND, IN 47374		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE CONTRIBUTION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
0000						
Bldg. 00						
2.49.00	This visit was fo	or the Investigation of	F 0000	Submission of this plan of		
		00226575, IN00227190,				
	IN00230907 ar			correction does not constitut	e	
	11100250907 41	iu ii (00202000).		admission or agreement by t	he	
	Complaint IN00	0226575 - Substantiated.		admission of agreement by t		
	-	eficiencies related to the		provider of the truth of facts		
		cited at F226, F329, F332,				
	F354, F425 and			alleged or correction set forth	non	
	100 ., 1 .20 unu			the statement of deficiencies	i.	
	Complaint IN00	0227190 - Substantiated.				
	-	eficiency related to the		This plan of correction is		
	allegations is cit	•		prepared and submitted beca	91159	
	Complaint IN00	0230907 - Substantiated.		of requirement under state a	nd	
	· ·	eficiencies related to the				
		cited at F312, F329, F332,		federal law. Please accept th	lis	
	F354 and F425.			plan of correction as our cred	dible	
	1 554 and 1 425.					
	Complaint IN00)232339 - Substantiated.		allegation of compliance. Inc	luded	
	r r	eficiencies related to the		all auditing tools and policies		
		cited at F332, F354, F425		all auditing tools and policies	j	
	and F465.	2100 at 1 552, 1 554, 1 425		used for in-servicing as		
				-		
	Survey dates: I	une 12, 13, 14, 15 and 16,		attachments Placed deficien	су	
	2017	une 12, 13, 14, 15 and 10,		coding on each attachment f	or	
	2017					
	Facility number	·· 000135		reference. Due to relative lo	w	
	Provider number			scope and severity, the prov	ider	
				respectfully asks for a desk		
	AIM number: 1	100200820		review in lieu of a post surve revisit.	у	
	Census Bed Typ	pe:				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

07/13/2017

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

 MAN SERVICES
 FORM APPROVED

 AID SERVICES
 OMB NO. 0938-0391

 X1) PROVIDER/SUPPLIER/CLIA
 X2) MULTIPLE CONSTRUCTION
 X3) DATE SURVEY

 IDENTIFICATION NUMBER:
 A. BUILDING
 00

 155230
 B. WING
 06/16/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

ROSEBL	JD VILLAGE		2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
			(EACH CORRECTIVE ACTION SHOPLINE DEFICIENCY)				
	 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, 						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING	CONSTRUCTION 00	CON 06/*	te survey 1pleted 16/2017
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD		3	
ROSEB	JD VILLAGE			IMOND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	facilities must als staff that at a min (c)(1) Activities the neglect, exploitate of resident prope (c)(2) Procedures abuse, neglect, emisappropriation (c)(3) Dementian abuse prevention Based on intervention Based on intervention the facility faile employees emp days had a mining checked prior to facility. (LPN #	requirements in § 483.12, o provide training to their imum educates staff on- nat constitute abuse, ion, and misappropriation rty as set forth at § 483.12. Is for reporting incidents of xploitation, or the of resident property management and resident i. iew and record review, d to ensure 5 of 5 loyed within the last 120 mum of two references o employment with the #1, CNA #3, CNA #4, ICF (Memory Care	F 0226	F 226 Develop/Implemen Abuse/Neglect, ETC. Pol		07/16/20
	Facilitator) #6). Findings includ During review of 6-16-17 at 10:4 within the last 1 employees, LPN and CNA #5 ha any reference cl previous emplo references prior 5 employees, M	e: of employee records on 5 a.m., of employees hired		What corrective action(side) be accomplished for those residents found to have if affected by the deficient practice. All staff to be educated/in-serviced on A Prohibition, Reporting, and Investigation Policy and	been	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING <u>00</u> B. WING		00	COMPLETED 06/16/2017	
NAME OF				STREET	ADDRESS, CITY, STATE, ZIP CC	DDE	
NAME OF	PROVIDER OR SUPPLIE	R		2050 C	HESTER BLVD		
ROSEBU	JD VILLAGE		RICHMOND, IN 4737		IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	In an interview	with the Executive			Procedure.		
	Director on 6-1	6-17 at 12:30 p.m., she					
	explained, "As	explained, "As you know, we had several					
	positions open,	including our CEC			ED or Designee to educ	cate staff	
	[Clinical Educa	tion Coordinator], who			responsible for hiring or		
	-	s new employee's			appropriate hiring proce		
	-	recently discovered			as How to conduct refer checks and who should		
		were employed without			references, a packet on		
	reference check	1.2			reference check/helpful		
					be used to provide educ	cation and	
	On 6-13-17 at 1	:30 p.m., the Director of			given copies and a sign		
		ed a copy of a policy			will be placed in the em file for every departmen		
		e Prohibition, Reporting			that was in-serviced/edu		
		on." This policy has a					
	•	11-2016 and was					
		the policy currently					
		acility. This policy					
		the policy of [name of					
	-						
	· ·	protect residents from			How other residents ha	aving the	
	-	physical abuse, sexual					
		ouse, mental abuse,			potential to be affected	бу	
	neglect, involur	2			same deficient practice	e will be	
		n of resident property					
		nd any physical/chemical			identified and what co	rrective	
		uired to treat the					
	resident's medic				action will be taken.		
		ployment screening is					
	done on all pote	ential employees"					
					All residents have the p	otential to	
	On 6-16-17 at 4:37 p.m., the	-					
		ed a copy of a document			be affected. All staff to b	be	
	entitled, "Perso	nnel and Confidential			educated/in-serviced or	n Abuse	
	Employee File	Checklist." This				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	document was u	indated, but indicated to			Prohibition, Reporting, a	and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Investigation Policy and be the current procedure utilized by Procedure. Human Resources to ensure all necessary documentation was present for each employee file. This document identified each file should have a minimum of two What measures will be put into reference checks conducted prior to new place or what systemic hire orientation. changes will be made to This Federal tag relates to Complaint ensure that the deficient IN00226575. practice does not recur. 3.1-14(a) All staff including Management to be Educated/in-serviced on Abuse Prohibition. Reporting, and Investigation Policy and Procedure By 06/30/2017 per ED/DNS ED or Designeesto educate staff responsible for hiring on the appropriate hiring process as well as how to conduct reference checks and who should check references, a packet on the reference check/helpful hints will be used to provide education and given copies and a signed copy will be placed in the employees file for every department head that was in-serviced/educated. By 06/30/2017 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 5 of 45

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07/13/2017

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE C A. BUILDING B. WING	construction <u>00</u>	COM	e survey pleted 6/2017
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD			
ROSEB	JD VILLAGE			MOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCE TO THE APP DEFICIENCY)	TTION JLD BE ROPRIATE	(X5) COMPLETION DATE
				How the corrective action be monitored to ensure deficient practice will no	the	
				HR will not continue with orientation or the hiring p until all areas have been completed. HR and CEC will work to ensure all back-ground c reference checks, TB tes drug screens have been completed prior to orienta job offer.	rocess gether to hecks, its, and	
				By what date the system changes will be comple		
- 0312	483.24(a)(2)			07/16/2017		
SS=D Bldg. 00	RESIDENTS (a)(2) A resident	VIDED FOR DEPENDENT who is unable to carry out living receives the es to maintain good				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMP	LETED
		155230	B. WI	NG		06/16	6/2017
NAME OF	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP CODE		
					CHESTER BLVD		
ROSEB	JD VILLAGE			RICHM	10ND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	hygiene.	ng, and personal and oral					
		view and record review,	F 03	312	F312 ADL Care provided for		07/16/201
	the facility faile		1 03	12	dependent residents		07/10/201
	documentation regarding bathing and hygiene was conducted in a congruent manner to provide an accurate reflection of the care provided to 3 of 3 residents				What corrective action will b	e	
					accomplished for those		
					residents found to have bee	n	
	-				affected by the deficient practice?		
	-	memory care unit,					
		eanliness. (Resident C,			POC documentation was		
	Resident D and	Resident E)			reviewed for resident C, D, ar		
					for accuracy. Showers and/ o	r	
	Findings includ	le:			bed baths were provided as indicated. Residents will be		
					showered/complete bed bath		
	1. The clinical	record of Resident C was			twice weekly or per preference	e.	
	reviewed on 6-	13-17 at 2:25 p.m. Her					
	diagnoses inclu	ded, but were not limited			How other residents having		
	to, dementia, ge	eneral muscle weakness			potential to be affected by the		
	and metabolic e	encephalopathy. It			same deficient practice will identified and what corrective		
		esided on the memory care			actions will be taken?	/e	
		ity since admission, over					
		. Review of her most			Audit will be completed by		
		m Data Set (MDS)			Activities/MCF/designee of		
		ed 3-4-17, indicated she is			preferences for showers for		
	,	nitively impaired, requires			residents by July 16, 2017. Shower schedules will be		
		ance of one person for			adjusted as indicated by July	16.	
		•			2017. Preferences will be	,	
		es and is dependent of one			assessed upon admission,		
	-	ing services. It indicated			annually with MDS schedule	and	
		er for mobility with			when requested by resident, family, guardian or POA. Sho	Wor	
	limited assistan	ce of one person.			sheets and POC documentat		
	The memory of	ro unit's bothing colordor			will be reviewed for accuracy		
	-	are unit's bathing calendar			7/16/17 and addressed as		
		ent C was to receive a			indicated.		
	snower or com	plete bed bath twice			What measures will be put i	nto	
	1						1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	СОМ	'e survey pleted 6/2017
	PROVIDER OR SUPPLIE	R	2050	ET ADDRESS, CITY, STATE, ZIP () CHESTER BLVD	CODE	
ROSEB	UD VILLAGE		RICH	HMOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	 weekly on the r and Thursday. Review of the f electronic docu May and June, C received a sh bath on 5-1-17, shift, 5-2-17, on night shift, 5-8- 5-11-17, on nig shift, 5-18-17, o on night shift. Review of the c reports, comple time period, inc received a show on 5-1-17, 5-4- 	acility's "Point of Care" mentation for bathing for 2017, indicated Resident ower or complete bed on the night and evening n evening shift, 5-4-17, on 17, on night shift, ht shift, 5-15-17, on night on night shift and 6-12-17, corresponding shower ted by hand, for the same licated Resident C ver or complete bed bath 17, 5-11-17, 5-15-17, 7, 6-1-17, 6-4-17, 6-8-17,		place or what system changes will be made ensure that the defici practice does not recRe-education will be provided and the deficient practice does not recRe-education will be provided and the deficient nursing on accurate documentation of show POC and use of show by 7/16/17. Certified r assistants to have a sl validation completed by 2017. RAI specialist to coding re-education will tra sheets a minimum of wensure showers/comp baths are given per assistent to ensure showers/comp baths are given per assistent to ensure showers/comp baths are given per assistent to ensure the maintained to ensure deficient practice will i.e., what quality assure program will be put in	e to ient cur? provided for wers in er sheets nursing hower skills by July 16, o do ADL ith nursing ck shower weekly to lete bed ssigned ve actions ure the I not recur, urance	
	Resident C on 6 shared, "I know shower twice a I'm not sure she weekOverall, In interview wi on 6-15-17 at 1 staff are expect	with a family member of 5-13-17 at 4:52 p.m., she of she is supposed to get a week, on evening shift. e even gets one a she seems fairly clean." th the Director of Nursing :30 p.m., she indicated the ed to document on the me handwritten "shower		DNS/designee is resp the completion of the Accommodation of neu- tool weekly x 4 weeks 6 months and then qu continued compliance maintained for two cor quarters. The results audits will be reviewed monthly QAPI meeting by the ED. If the three 95% is not achieved a	o ensure compliance, the NS/designee is responsible for the completion of the ccommodation of needs QAPI pol weekly x 4 weeks, monthly x months and then quarterly until pontinued compliance is maintained for two consecutive uarters. The results of these udits will be reviewed during monthly QAPI meeting, overseen y the ED. If the threshold of 5% is not achieved an action lan will be developed to ensure	

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Event ID: 2

2PZ111 Fac

Facility ID: 000135

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
ANDILAN	of connection	155230	B. WING	00	06/16/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	I	
	PROVIDER OR SUPPLIE	CK		HESTER BLVD		
ROSEBI	JD VILLAGE		RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OPRIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	the electronic v	ersion and handwritten		action taken as needed.		
	version being c	onsistent.				
	2 The distant	record of Resident D was				
		13-17 at 12:45 p.m. His				
	-	ded, but were not limited				
		disease, difficulty				
		neral muscle weakness.				
	It indicated he	resided on the memory				
	care unit of the	facility for over one year.				
	Review of his r	nost recent Minimum				
	Data Set (MDS) assessment, dated 3-1-17				
		severely cognitively				
		res extensive assistance of				
		rsons for hygiene services				
	-	nt of two or more persons				
	-	vices. It indicated he uses				
	-					
		bility with supervision				
	assistance of or	ne person.				
	Review of the f	acility's "Point of Care"				
		mentation for bathing for				
		2017, indicated Resident				
		ower or complete bed				
		4-5-17, 4-7-17, 4-9-17,				
	,					
		7, 4-16-17, 4-18-17,				
		on 4-24-17, 4-25-17,				
		twice on 5-4-17, 5-16-17,				
	5-19-17, 5-22-1	7, and 5-26-17.				
	Review of the c	corresponding shower				
		ted by hand, for the same				
		-				
	· ·	licated Resident D				
	received a show	ver or complete bed bath		1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING		CON 06/	te survey 19leted 16/2017
	PROVIDER OR SUPPLIE	R	205	EET ADDRESS, CITY, STATE, 2 0 CHESTER BLVD	ZIP CODE	
ROSEB	JD VILLAGE		RIC	HMOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
		17, 4-7-17, 4-12-17, , 5-4-17, 5-5-17, 5-7-17				
	Resident D on 6 stated he had "W without shower him soaking we basis, even with would just clear shared that she Nursing and the her concerns re	with a family member of 5-13-17 at 2:59 p.m., she Went for 1 and 1/2 weeks or shavedWould find t or dirty on a regular the Depends on. So I him up myself." She had met with Director of Administrator to discuss garding Resident D, but him to another nursing				
	on 6-15-17 at 1 staff are expect computer and th sheets," with th	th the Director of Nursing 30 p.m., she indicated the ed to document on the he handwritten "shower e documentation between ersion and handwritten onsistent.				
	reviewed on 6- diagnoses inclu to, dementia wi and Parkinson's resided on the r facility since ad years ago. Re	record of Resident E was 44-17 at 12:40 p.m. His ded, but were not limited th behavioral disturbances disease. It indicated he memory care unit of the mission, nearly three view of his most recent Set (MDS) assessment,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG dated 4-3-17, indicated he is severely cognitively impaired, requires extensive assistance of one person for hygiene services and is dependent of one person for bathing services. It indicated is independently mobile. The memory care unit's bathing calendar indicated Resident E was to receive a shower or complete bed bath twice weekly on the night shift of each Tuesday and Saturday. Review of the facility's "Point of Care" electronic documentation for bathing for May and June, 2017, indicated Resident E received a shower or complete bed bath on 5-1-17, 5-2-17, 5-10-17, 5-20-17, 5-22-17, 5-24-17, 5-27-17, 6-7-17 and 6-10-17. Review of the corresponding shower reports, completed by hand, for the same time period, indicated Resident E received a shower or complete bed bath on 5-1-17, 5-6-17, 5-10-17, 5-13-17, refusal, but agreed to a partial bath, 5-19-17, refusal with no documentation of other type of bathing offered or attempted, 5-22-17, 5-24-17, 5-27-17, 6-3-17 and 6-10-17. In interview with the Director of Nursing on 6-15-17 at 1:30 p.m., she indicated the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 11 of 45

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG staff are expected to document on the computer and the handwritten "shower sheets," with the documentation between the electronic version and handwritten version being consistent. This Federal tag relates to Complaint IN00230907. 3.1-38(b)(2) F 0329 483.45(d) DRUG REGIMEN IS FREE FROM SS=D Bldg. 00 UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. F329 Drug Regimen is Free Based on observation, interview and F 0329 07/16/2017 from Unnecessary Drugs record review, the facility failed to

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Event ID: 2PZ111

Facility ID: 000135

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07/13/2017

TATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CC	INSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155230	B. WING			06/16/2017	
AME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD		
ROSEBL	JD VILLAGE		RICHMOND, IN 47374				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	п	D	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
		monitoring of blood			What corrective action will be	e	
	pressure assessi	ments related to the use of			accomplished for those residents found to have beer		
	antihypertensiv	e medications for 2 of 3			affected by the deficient	1	
	residents review	ved for medication			practice?		
	accuracy. (Rest	ident F and Resident G)			P . 2 01001		
		,			Orders were obtained for resid	lent	
	Findings includ	e.			F and G to obtain blood press	ure	
	i manigo moraa				before administration of		
	1 The clinical	record of Resident F was			medication, with hold paramet	ers	
		15-17 at 2:15 p.m. Her			as indicated and to notify physician when indicated		
		•			physician when indicated		
		ded, but were not limited			How other residents having t	the	
	to, hypertension	and Alzheimer's disease.			potential to be affected by th	е	
					same deficient practice will b	e	
	A review of the	May and June, 2017,			identified and what corrective	е	
	recapitulation o	rders included physician's			actions will be taken?		
	orders for the fo	ollowing medications:			Audit of all MADS was sample	tod	
	hydrochlorothia	zide (a diuretic), 25			Audit of all MARS was comple on June 16, 2017 and orders	leu	
) daily by mouth.			were obtained for blood press	ure	
		ochlorothiazide (a			monitoring with parameters in		
		oduct of a blood pressure			place for residents receiving		
	-	a diuretic for blood			Antihypertensive medications.		
		l) $20/25$ mg daily by				4	
	<u>^</u>	ter supply of 20 mg is			What measures will be put in place or what systemic	10	
	complete."	tor suppry of 20 mg is			changes will be made to		
	-	arata (used for beert			ensure that the deficient		
	-	arate (used for heart			practice does not recur?		
	-	essure issues) 5 mg daily					
	by mouth.				DNS/Designee will re-educate		
					nurses on monitoring blood	a	
		e physician orders, an			pressures before administering hypertensive medications and		
	order, dated 4-6	5-17, stipulated to start			notification of MD/ and or hold		
	lisinopril-hydro	chlorothiazide 20/25 mg			medication if indicated when E	-	
	daily by mouth	upon completion of the			out of range by 7/16/17.		
		y of 20 mg. There was			DNS/designee will ensure that	all	
		clarification physician's			new orders for hypertensive medications have proper order		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	<u>00</u>	(X3) DATE SURVEY COMPLETED
		155230	B. WING		06/16/2017
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
ROSEB	JD VILLAGE			CHESTER BLVD MOND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	TAG		
		to continue the		with parameters in place and a nurses/QMA's will complete a	11
		azide 25 milligrams daily		medication pass procedure	
	by mouth in ad	dition to the		validation by July 16, 2017.	
	lisinopril-hydro	ochlorothiazide 20/25 mg			
	daily by mouth			How will the corrective action	ıs
				be maintained to ensure the	
	Review of the M	MAR (medication		deficient practice will not rec	ur,
		record) for May and June,		i.e., what quality assurance program will be put into place	~2
	2017, indicated	•		program will be put into place	31
	,	ochlorothiazide 20/25 mg		To ensure compliance, the	
	daily by mouth	-		DNS/designee is responsible f	
		azide 25 milligrams daily		the completion of the Assessm	
	-	administered 5-1-17,		with Antihypertensive QAPI too	
		7, and 6-1-17, through		weekly x 4 weeks, monthly x 6 months, and then quarterly unt	
		•		continued compliance is	
		isoprolol fumarate 5 mg		maintained for two consecutive	÷
		was documented as		quarters. The results of these	
		-1-17, through 5-31-17,		audits will be reviewed during	
	and 6-1-17, three	ough 6-15-17.		monthly QAPI meeting, overse by the ED. If the threshold of 9	
	In review of do	cumented blood pressure		is not achieved an action plan	will
		dent F for the time period		be developed to ensure	
		17, the following blood		compliance and disciplinary action taken as needed.	
		gs were present in the		action taken as needed.	
	-				
	clinical record:				
	-4-6-17: 138/7				
	-4-7-17: 129/6				
	-4-8-17: 150/7				
	-4-9-17: 148/6				
	-4-22-17: 129/				
	-5-20-17: 114/				
	-6-7-17: 111/6	1.			
	-6-8-17: 144/5	8.			
	-6-10-17: 138/	84.			
			1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG In interview with the Director of Nursing on 6-16-17 at 9:45 a.m., she indicated facility staff should probably have been checking routine blood pressures on any resident receiving any blood pressure medication. In an interview with the contracted Pharmacy Consultant on 6-16-17 at 10:43 a.m., regarding the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth and the hydrochlorothiazide 25 milligrams daily by mouth, she relayed, "I can't really tell you why I didn't look into that in more detail; normally like to see the hydrochlorothiazide around 25 mg daily, even though a 50 mg dose is within acceptable boundaries." 2. The clinical record of Resident G was reviewed on 6-15-17 at 2:30 p.m. Her diagnoses included, but were not limited to, hypertension and Alzheimer's disease. A review of the May and June, 2017, recapitulation orders included physician's orders for the following medications: -metoprolol tartrate (used for blood pressure control) 25 mg daily by mouth. -isosorbide MN ER 60 mg daily by mouth. Review of the MAR (medication FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 15 of 45

PRINTED:

07/13/2017

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155230	B. WING		06/16	/16/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	CODE		
ROSEB	ROSEBUD VILLAGE			CHESTER BLVD MOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORI		RECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC DATE	
	administration	record) for May and June,					
	2017, it specifi	ed the metoprolol tartrate					
	25 mg daily by	mouth was administered					
		h 6-6-17 and 6-8-17					
	•	7, with one missed dose					
	•	s missed dose had an					
		ntation block, with no					
		nation for the reason it					
	was not admini						
		MN ER 60 mg daily by					
		ered effective of 5-26-17,					
		istered on 5-29-17,					
		7, 6-2-17, 6-4-17, 6-7-17,					
		6-10-17, 6-11-17, and					
		IAR specified this					
		not administered on					
		7, 6-1-17, 6-3-17, 6-5-17,					
		7, 6-14-17, and 6-15-17, as					
	,						
		administrator's initials					
	•	. The non-administration					
		, 6-14-17 and 6-15-17, had					
		e back-side of the MAR					
		the isosorbide 60 mg was					
		r administration, with					
	•	in documentation for the					
	remaining dates	3.					
	The clinical rec	ord for 5-26-17 to					
		0 a.m., failed to document					
		to the physician of blood					
	-	ations being unavailable.					
		cumented blood pressure dent G for the time period					

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MUL A. BUIL B. WINC		TRUCTION 00	CC	ATE SURVEY DMPLETED 5/16/2017
NAMEOF	PROVIDER OR SUPPLIE	D.		STREET ADI	DRESS, CITY, STATE, ZIP COD	E	
					STER BLVD		
	JD VILLAGE				ND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
		-17, the following blood					
		gs were present in the					
	clinical record:	Bs were present in the					
	-5-26-17: 141/3	83					
	5-27-17: 106/6						
	5-28-17: 117/6						
	5-29-17: 107/6						
	5-30-17: 117/6						
	6-2-17: 116/67						
	6-4-17: 124/68						
	6-6-17: 172/76						
	6-8-17: 129/77						
	In interview wi	th the Director of Nursing					
		:45 a.m., she indicated					
		ould probably have been					
	-	e blood pressures on any					
	resident receivi medication.	ng any blood pressure					
		g relates to Complaint					
	1N00226575 an	d Complaint IN00230907.					
	3.1-48(a)(3)						
F 0332 SS=E Bldg. 00	OF 5% OR MOR						
-	(f) Medication En ensure that its-	rors. The facility must					
	or greater;	ror rates are not 5 percent					
		vation, interview and the facility failed to ensure	F 033	-	332 Free from medicat rror rates of 5% or mor		07/16/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155230	B. WING		06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
DOCEDI						
	JD VILLAGE		RICHI	10ND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPL	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DAT	IE
		medication error rate of		What corrective action will b)e	
	-	ercent (%) for 2 of 8		accomplished for those		
		ved during medication		residents found to have bee	n	
	1	cation errors were		affected by the deficient		
		g 31 opportunities for		practice?		
	error in medica	tion administration. This		Discription and Discription (6 1	
	resulted in a 19	.3% medication error rate.		Physician and Pharmacy noti of medications needed.	ried	
	(Resident F and	l Resident G)		Medications were administered	-h	
				as indicated. Hold orders wer		
	Findings includ	e:		obtained as appropriate. Res	ident	
	•	dication administration		assessments were completed		
	-	6-15-17 at 8:52 a.m., for		indicated for resident F and G	i	
		1 LPN #1, LPN #1 was		How other residents having	the	
		pare the following		potential to be affected by the		
	medications:	pare the following		same deficient practice will		
	-Ocuvite Adult	50+ Softgel (a		identified and what corrective	ve	
		one softgel, daily by		actions will be taken?		
	mouth.			All residents who receive		
		azide (a diuretic), 25		medications have the potentia	al to	
	-) daily by mouth.		be affected by this deficient		
		ochlorothiazide (a		practice. An audit will be		
	1 2	oduct of a blood pressure		completed by Omnicare by Ju		
	1	a diuretic for blood		16, 2017 to ensure all ordered medications are available for	L	
				administration. Medications w	/ill	
	-	l) 20/25 mg daily by		be obtained if indicated.		
		fter supply of 20 mg is				
	complete."			What measures will be put i	nto	
		ed for allergy control) 10		place or what systemic		
	mg daily by mc			changes will be made to ensure that the deficient		
		used for hyperthyroidism)		practice does not recur?		
	5 mg daily by n					
	-Namenda XR	(used for dementia) 28 mg		Pharmacy to audit resident's		
	daily by mouth			medications to ensure		
	-potassium (sur	pplement) ER 20		medications are available for		
		daily by mouth.		administration by July 16, 20 All nurses/QMA's will be	17.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOD MEDICADE & MEDICAID SEDVIC

	R MEDICARE & MEDI			ONGEDUCTION	OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		06/16/2017
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
				CHESTER BLVD	
ROSEBI	JD VILLAGE		RICHM	10ND, IN 47374	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-Flonase (allerg	gy medication) 50		re-educated on medication	pass
	micrograms (m	cg) one spray in each		and steps to take when a	
	nostril daily.			mediation is unavailable by 7/16/17 by DNS or designed	_
				CEC/ designee will complet	
	Upon preparing	the above medications,		Medication Administration S	
		served to administer the		Validation with nurses and (QMAs
	medications to Resident F. Aft			by 7/16/17. All new hire Nur	
				and QMAs will be checked	
		inistration of these medications, LPN nared she was unsure of the		the Medication Administration	
			Skills validation tool by CEC or designee prior to working on the		
		Ocuvite and Cerovite. At		floor independently.	
	9:58 a.m., she s	shared that she was unable			
	to administer se	everal medications that she		How will the corrective act	ions
	could not locate	e, specifically the		be maintained to ensure the	e
	following medi	cations:		deficient practice will not i	
	-bisoprolol fum	arate (used for heart		i.e., what quality assuranc	
	-	ressure issues) 5 mg daily		program will be put into pl	ace?
	by mouth.			To ensure compliance, the	
	-	(supplement) 1000 mcg		designee will observe 5	5110/
	daily by mouth			medication passes using the	e
				Medication Administration S	
		ng with (vitamin		check off tool weekly x 4 we	
	supplement) D-			monthly x 6 months, and the	en
	× 11 /	nce daily by mouth.		quarterly until continued	r two
		nced Formula (vitamin		compliance is maintained for consecutive quarters. The r	
	supplement) on	ce daily by mouth.		of these audits will be review	
				during monthly QAPI meeting	
	LPN #1 was the	en observed to locate		overseen by the ED. If three	
	several of the n	nedications, specific to		of 95% is not achieved, an a	
	Caltrate 600 ms	g with (Vitamin) D-3 and		plan will be developed to en	
		minerals, vitamin B-12 and bisoprolol		compliance and disciplinary action taken as needed.	
		hose were administered			
		a.m., and 10:15 a.m. The			
		time listed for each of			
		ons was listed as 8:00 a.m.			
	She was unable	to locate the Cerovite			

2PZ111 Facility ID: 000135

If continuation sheet Page 19 of 45

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STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	AID SERVICES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	A. I	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 06/16/2017	
	PROVIDER OR SUPPLIER		•	2050 CH	DDRESS, CITY, STATE, ZIP HESTER BLVD	P CODE		
ROSEB	JD VILLAGE			RICHMO	OND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
	Advanced Forma administered.	ula and it was not						
	order, dated 4-6- lisinopril-hydrod daily by mouth u lisinopril supply not a follow up of order to specify hydrochlorothiaz by mouth in add lisinopril-hydrod daily by mouth. (medication adm May and June, 2 lisinopril-hydrod daily by mouth a hydrochlorothiaz by mouth were a	zide 25 milligrams daily ition to the chlorothiazide 20/25 mg Review of the MAR inistration record) for 017, it indicated both the chlorothiazide 20/25 mg						
	Pharmacy Consu a.m., regarding t lisinopril-hydroc daily by mouth a hydrochlorothiaz by mouth, she re you why I didn't detail; normally hydrochlorothiaz	hlorothiazide 20/25 mg ind the zide 25 milligrams daily layed, "I can't really tell look into that in more						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILI		NSTRUCTION 00	. ,	TE SURVEY APLETED
	or contection	155230	B. WING		00	06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE				
ROSEBI	JD VILLAGE				HESTER BLVD OND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROCK DEFENSION TO THE ADDR	D BE	(X5) COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	1	ſAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
	acceptable bour	ndaries."					
	In review of the	medication orders for					
	Resident F, afte	r the medication					
		observation, an order for					
		50+ Softgel could not be					
		ecapitulation orders for					
		an interview with the $\frac{1}{12}$ at 0.45					
		sing on 6-16-17 at 9:45 ed the order for this					
	· · · ·	discontinued on 5-11-17,					
	by the physician						
		ns from the pharmacy					
		-9-17, as possible					
		by of Ocuvite and					
	Cerovite. The I	May and June, 2017,					
	MAR indicated	the daily dose of Ocuvite					
		ed 5-12-17, through					
	5-31-17, and on	6-15-17.					
	On 6-16-17 at 1	0:00 a.m., the Corporate					
	-	a listing of the current					
		dication Supplies for					
		al medications. This list					
	did not include	Cerovite.					
	2. During a me	dication administration					
		6-15-17 at 8:39 a.m., for					
		n LPN #1, LPN #1 was					
		pare the following					
	medications:						
	_	sed for gout) 100 mg					
	(milligrams) da						
	-Calcium 600 n	ng with vitamin D					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	A.	MULTIPLE CC BUILDING WING	DNSTRUCTION 00	COMPLETH 06/16/20	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	P CODE	
ROSEB	UD VILLAGE				HESTER BLVD IOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
	one tablet daily -Loratadine (use mg daily by mo -metoprolol tart pressure control -ranitidine (used reducer) 150 mg -vitamin D-3 (s daily by mouth. -vitamin B-12 (daily by mouth. -vitamin B-12 (daily by mouth. Upon preparing LPN #1 was ob medications to 1 administration of #1 shared one n available and sh medication, isos daily by mouth. In review of the Resident G, upo medication adm the MAR (medi record) for May reviewed. It ind ER 60 mg daily effective of 5-2 administered or 5-31-17, 6-2-17 6-9-17, 6-10-17	ed for allergy control) 10 uth. rate (used for blood l) 25 mg daily by mouth. d as a stomach acid g daily by mouth. upplement)2000 units supplement) 1000 mcg the above medications, served to administer the Resident G. After the of these medications, LPN nedication was not ne was unable to locate the sorbide MN ER 60 mg e medication orders for on completion of the inistration observation, cation administration and June, 2017, was dicated the isosorbide MN by mouth was ordered					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG not administered on 5-27-17, 5-28-17, 6-1-17, 6-3-17, 6-5-17, 6-6-17, 6-13-17, 6-14-17, and 6-15-17, as signified by the administrator's initials being encircled. The non-administration dates of 6-3-17, 6-14-17 and 6-15-17, had a notation of the back-side of the MAR which clarified the isosorbide 60 mg was not available for administration, with nothing similar in documentation for the remaining dates. The clinical record for 5-26-17 through 6-15-17 at 10:00 a.m., failed to document any notification to the physician of the blood pressure medication being unavailable. In an interview with the Director of Nursing (DON) on 6-16-17, she provided a medication shipment list for Resident G, dated 5-27-17. This document indicated on 5-28-17 at 12:16 a.m., LPN #2 signed for a medication delivery which included, but was not limited to, isosorbide MN ER 60 mg of 30 tablets. In an interview with the DON at this time, she explained LPN #2 was told at the time of delivery there was an issue with the insurance coverage for this medication and only 7 doses were received. "Narcotics must be checked immediately; others [non-narcotic medications, we] have 24 hours to check and notify the pharmacy of [any FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 23 of 45

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG discrepancies] of the deliveries. [We] have nothing to show [any] discrepancy." As of 6-16-17 at 4:50 p.m., the DON indicated she had yet to hear back from the contracted pharmacy in regard to the actual number of doses that were dispensed of isosorbide MN ER 60 mg to Resident G. On 6-16-17 at 10:00 a.m., the Corporate Nurse provided a listing of the current **Emergency Medication Supplies for** non-narcotic oral medications. This list did not include isosorbide MN ER 60 mg. On 6-16-17 at 4:37 p.m., the DON provided a copy of a policy entitled, "Medication Shortages/Unavailable Medications." This policy had a revision date of 1-1-13 and was indicated to be the current policy utilized by the facility. This policy specified, "Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy...If a medication shortage is discovered during normal Pharmacy hours: Facility nurse should call Pharmacy to determine the status of the order...If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 24 of 45

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07/13/2017

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	construction 00	(X3) DATE S COMPL	ETED
		155230	B. WING		06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	ĒR		TADDRESS, CITY, STATE, ZIP C	CODE	
DOOFD				CHESTER BLVD		
ROSEB	UD VILLAGE		RICH	MOND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)		DATE
		otain the medication from				
		Medication Supply to				
		lose. If the medication is				
		the Emergency				
	-	pply, Facility staff should				
	1 -	y and arrange for an				
	emergency deli	very. If a medication				
	shortage is disc	overed after normal				
	Pharmacy hour	s: A licensed nurse				
	should obtain the	ne ordered medication				
	from the Emerg	gency Medication Supply.				
	If the ordered n	nedication is not available				
	in the Emergen	cy Medication Supply, the				
	licensed Facilit	y nurse should call				
	Pharmacy's em	ergency answering service				
	and request to s	peak with the registered				
	pharmacist on c	luty to manage a plan of				
	action. Action	may include: Emergency				
		of an emergency				
	-	l Party Pharmacy. If an				
	· • •	very is unavailable,				
		contact the attending				
	5	tain orders or directions.				
		on is unavailable from				
		Third Party Pharmacy, and				
	cannot be suppl					
		Facility should obtain				
		cian/Prescriber orders, as				
	necessary. If th					
	-	m Pharmacy due to				
		rage, contraindicationor				
	-	ason, Facility should				
		-				
		h Pharmacy and				
	rilysician/presc	criber to determine		1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	A. 1	MULTIPLE CO BUILDING VING	nstruction 00	COM	te survey apleted 16/2017
	PROVIDER OR SUPPLIE	3		2050 CI	DDRESS, CITY, STATE, ZIP HESTER BLVD OND, IN 47374	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	missed dose is u nurse should do and the explanat on the MAR or administration r notes per Facilit documentation s following inforr the circumstance shortage; A deso response upon n taken."	ecord] and in the nurse's y policy. Such should include the nation: A description of es of the medication cription of Pharmacy's otification; and Action(s)					
⁻ 0354 SS=E Bldg. 00	or (f) of this section services of a regist consecutive hours	waived under paragraph (e) on, the facility must use the stered nurse for at least 8 s a day, 7 days a week.					
	or (f) of this section	vaived under paragraph (e) on, the facility must tered nurse to serve as the u on a full time basis					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		06/16/2017
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
	JD VILLAGE			CHESTER BLVD /IOND, IN 47374	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO DATE
TAG		of nursing may serve as a	IAG		DATE
		y when the facility has an			
		cupancy of 60 or fewer			
	residents.				
	Based on interv	riew and record review,	F 0354	F 354 RN 8 hours/ 7 days a	07/16/201
	the facility faile	ed to ensure eight		week, full time DON	
	consecutive how	urs of RN staffing on a		What corrective action will be	
		he facility. This deficient		accomplished for those	
	practice has the	potential to negatively		residents found to have been	
	~	and services of all 91		affected by the deficient	
	residents in the			practice?	
				Facility has hired two RN charg	e
	Findings include:	e:		nurses who are currently in	
				orientation. Rotation of nurse management staff to ensure RN	J
	-	posted staffing on 6-13-17		coverage by July 16, 2017. Full	
		emonstrated the posted		time DON on staff.	
		and 6-9-17, reflected no			
	-	n those dates for those 24		How other residents having th	
	-	Review of the posted		potential to be affected by the	
	staffing on 6-13	3-17 at 1:35 p.m.,		same deficient practice will be identified and what corrective	
	demonstrated th	ne posted dates for		actions will be taken?	
	6-12-17 and 6-1	13-17, reflected no RN			
	coverage on the	ose dates for those 24 hour		All residents have the potential	to
	periods.			be affected by this deficient	.
				practice. DNS/designee will wo with scheduler to ensure 8-hour	
	In an interview	on 6-13-17 at 1:30 p.m.,		RN coverage is obtained and	
		or of Nursing (DON), she		Nurse Management rotation to	be
		Ve currently do not have		implemented to ensure 8-hour	
		ge, except for myself, the		RN coverage.	
	-	ant Director of Nursing)			
		Clinical Education			
	Coordinator)."			What measures will be put int	。
				place or what systemic	-
	0n 6 14 17 ot 1	1:05 a.m., the DON		changes will be made to	
				ensure that the deficient	
	provided copies	s of the time records for	1		

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	CON	MPLETED
		155230	B. WING			06/16/2017	
				STREET	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	ER		2050 C	HESTER BLVD		
ROSEB	JD VILLAGE			RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	herself, the AD	ON and the CEC for the			practice does not red	cur?	
	dates 5-28-17 tl	hrough 6-14-17. The					
		the CEC had been on			DNS/designee will ov		
		prior week of 6-4-17			schedule in advance		
		•			8-hour RN coverage i		
	U U	7, beginning her official			maintained by July 16 DNS will initiate a nur		
		17. In review of the time			management rotation		
	records of the A	ADON for 5-28-17			8-hour RN coverage i		
	through 6-13-1	7, it indicated she was not			maintained by July 16		
	working on 5-2	8-17, 5-29-17, 6-3-17,					
	-	7, 6-11-17, and 6-12-17.			How will the correcti	ve actions	
	· · ·	n 6-2-17, her time record			be maintained to ens	sure the	
					deficient practice will		
	reflected she wa	as working only 7 hours.			ie., what quality assu		
					program will be put i	nto place?	
	This Federal tag	g relates to Complaint					
	IN00226575, II	N00227190, Complaint			To ensure compliance		
	IN00230907 an	d IN00232339.			designee is responsib completion of the RN	Coverage	
	2.1.17(h)(1)				QAPI tool weekly x 4 monthly x 6 months, a		
	3.1-17(b)(1)				quarterly until continu		
	3.1-17(b)(3)				compliance is maintai		
	3.1-17(e)				consecutive quarters.		
					of these audits will be		
					during monthly QAPI		
					overseen by the ED. I		
					of 95% is not achieve		
					plan will be developed		
					compliance and discip		
0425	483.45(a)(b)(1)						
SS=D		CAL SVC - ACCURATE					
Bldg. 00	PROCEDURES,						
		A facility must provide					
		services (including assure the accurate					
	procedures triat a				1		

STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X	(3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING	00	COMPLETED 06/16/2017	
NAME OF PROVIDER OR SUPPLIE	ĒR	2050 0	ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD MOND, IN 47374		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
administering of meet the needs of (b) Service Cons employ or obtain pharmacist who- (1) Provides cons the provision of p facility; Based on obser record review, to ordered medica administered at physician order errors or duplic pharmacy const of potential dup for 2 of 3 reside medication acct Resident G) Findings includ 1. During a me observation on Resident F with observed to pre medications: -Ocuvite Adult multi-vitamin), mouth. -hydrochlorothi milligrams (mg	ultation. The facility must the services of a licensed 	F 0425	 F425 Pharmaceutical services accurate procedures What corrective action will be accomplished for those residents found to have been affected by the deficient practice? MD and pharmacy notified of medications that were unavailab for resident F and G. MD orders were obtained as indicated. MD was in the facility at the time and provided an assessment of residents affected to ensure no adverse effects. Pharmacy was notified to send medications tha were needed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who receive medications have the potential to be affected by this alleged deficient practice. Pharmacy will complete an audit of all 	d t e	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTI A. BUILD B. WING		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/16/2017	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)) FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	medication and pressure contro mouth. "Start a complete." -Loratadine (us mg daily by mo				medications currently ordered ensure medications are availa for administration by July 17, 2017. Medications will be obtained as indicated. What measures will be put in	ıble	
	5 mg daily by n -Namenda XR daily by mouth.	(used for dementia) 28 mg			place or what systemic changes will be made to ensure that the deficient practice does not recur?		
	millequivalents -Flonase (allerg	pplement) ER 20 daily by mouth. y medication) 50 cg) one spray in each	y mouth. cation) 50		All nurses/QMA to be re-educated on medication pass procedure, ordering medications, physician notification when medications not available in EDK, pharmacy notification and timely verification of medications received from		
	LPN #1 was ob medications to administration #1 shared she w	the above medications, served to administer the Resident F. After the of these medications, LPN vas unsure of the			of medications received from pharmacy by July 16, 2017. Nurses and QMA's will be checked off on med pass by CEC/ designee, using the Medication Administration Skills Validation Tool by 7/16/17.		
	9:58 a.m., she s to administer se could not locate following medi	ared that she was unablebe maintainederal medications that shedeficient pracspecifically theie., what quali		How will the corrective actio be maintained to ensure the deficient practice will not red ie., what quality assurance program will be put into plac	cur,		
	and/or blood pr by mouth.	essure issues) 5 mg daily supplement) 1000 mcg			To ensure compliance, the DN designee is responsible for the completion of the Pharmacy Services QAPI tool weekly x 4 weeks, monthly x 6 months, a then quarterly until continued compliance is maintained for t	e I nd	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2PZ111

Facility ID: 000135

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	R MEDICARE & MEDI					MB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/16/2017	
	PROVIDER OR SUPPLI	ER	2050 0	^C ADDRESS, CITY, STATE, ZIP CODI CHESTER BLVD MOND, IN 47374	E	
						(175)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION ID BE OPRIATE	(X5) COMPLETIC DATE
	(supplement) of -Cerovite Adva supplement) or LPN #1 was th several of the r Caltrate 600 m minerals, vitarr fumarate, and t between 10:00 administration these medicatio unable to locate Formula and it In review of the order, dated 4-0 lisinopril-hydro daily by mouth lisinopril suppl not a follow up order to specify hydrochlorothi by mouth in ad lisinopril-hydro daily by mouth (medication ad May and June, lisinopril-hydro daily by mouth (medication ad May and June, lisinopril-hydro	nce daily by mouth. Inced Formula (vitamin ace daily by mouth. en observed to locate nedications, specific to g with (Vitamin) D-3 and hin B-12 and bisoprolol hose were administered a.m., and 10:15 a.m. The time listed for each of ons was 8:00 a.m. She was e the Cerovite Advanced was not administered. e physician orders, an 6-17, stipulated to start ochlorothiazide 20/25 mg upon completion of the y of 20 mg. There was o clarification physician's y to continue the azide 25 milligrams daily dition to the ochlorothiazide 20/25 mg . Review of the MAR ministration record) for 2017, it indicated both the ochlorothiazide 20/25 mg		of these audits will be revi during monthly QAPI mee overseen by the ED. If thr of 95% is not achieved, an plan will be developed to compliance and disciplina action taken as needed.	ting eshold n action ensure	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION <u>00</u>	(X3) DATE SI COMPLE	
		155230	B. WING	06/16/2	017	
NAME OF	PROVIDER OR SUPPLIE	ER	STREE	CODE		
ROSEB	JD VILLAGE			CHESTER BLVD MOND, IN 47374		
(X4) ID	SUMMARY	MMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	In an interview	with the contracted				
	Pharmacy Cons	sultant on 6-16-17 at 10:43				
	a.m., regarding	the				
	lisinopril-hydro	chlorothiazide 20/25 mg				
	daily by mouth	and the				
		azide 25 milligrams daily				
	by mouth, she relayed, "I can't really	• •				
		't look into that in more				
	detail; normally					
	-	azide around 25 mg daily,				
		•••				
	even though a 50 mg dose is within acceptable boundaries."					
	In review of the	e medication orders for				
	Resident F, afte	er the medication				
		observation, an order for				
		50+ Softgel could not be				
		ecapitulation orders for				
		an interview with the				
		sing on 6-16-17 at 9:45				
		ed the order for this				
		discontinued on 5-11-17,				
	by the physicia	· · · · · · · · · · · · · · · · · · ·				
		ins from the pharmacy				
		-9-17, as possible				
		by of Ocuvite and				
	· ·	May and June, 2017,				
		the daily dose of Ocuvite				
		ed 5-12-17, through				
	5-31-17, and or	-				
	On 6-16-17 at 1	0:00 a.m., the Corporate				
		a listing of the current				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155230 B. WING 06/16/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD ROSEBUD VILLAGE RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **Emergency Medication Supplies for** non-narcotic oral medications. This list did not include Cerovite. 2. During a medication administration observation on 6-15-17 at 8:39 a.m., for Resident G with LPN #1, LPN #1 was observed to prepare the following medications: -Allopurinol (used for gout) 100 mg (milligrams) daily by mouth. -Calcium 600 mg with vitamin D (supplement) 400 IU (international units) one tablet daily by mouth. -Loratadine (used for allergy control) 10 mg daily by mouth. -metoprolol tartrate (used for blood pressure control) 25 mg daily by mouth. -ranitidine (used as a stomach acid reducer) 150 mg daily by mouth. -vitamin D-3 (supplement)2000 units daily by mouth. -vitamin B-12 (supplement) 1000 mcg daily by mouth. Upon preparing the above medications, LPN #1 was observed to administer the medications to Resident G. After the administration of these medications, LPN #1 shared one medication was not available and she was unable to locate the medication, isosorbide MN ER 60 mg daily by mouth. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2PZ111 Facility ID: 000135 If continuation sheet Page 33 of 45

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
		155230	B. WING		06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODI	3	
ROSERI	JD VILLAGE			CHESTER BLVD 10ND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		
TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE DATE	
		e medication orders for				
		on completion of the				
		inistration observation,				
		ication administration				
		and June, 2017, was				
	, , ,	dicated the isosorbide MN				
		by mouth was ordered				
	effective of 5-2	•				
		1 5-29-17, 5-30-17,				
		, 6-4-17, 6-7-17, 6-8-17,				
		', 6-11-17, and 6-12-17.				
		ified this medication was				
	-	d on 5-27-17, 5-28-17,				
		6-5-17, 6-6-17, 6-13-17,				
		15-17, as signified by the				
		initials being encircled.				
		istration dates of 6-3-17,				
		5-17, had a notation of				
		f the MAR which clarified				
		0 mg was not available				
		on, with nothing similar				
		on for the remaining dates.				
		fill for the remaining dates.				
	The clinical rec	ord for 5-26-17 through				
		0 a.m. failed to document				
		to the physician of the				
	-	medications being				
	unavailable.	C				
	In on interrit	with the Director of				
		with the Director of $(16, 17, a)$				
		on 6-16-17, she provided				
		ipment list for Resident				
		7. This document				
	indicated on 5-2	28-17 at 12:16 a.m., LPN		1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	· /	ILDING	nstruction 00	(X3) DATE SURVEY COMPLETED 06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	ODE	
ROSEB	UD VILLAGE				HESTER BLVD OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	 which included isosorbide MN In an interview time, she explait the time of deli with the insurate medication and received. "Nare immediately; or medications, we and notify the p discrepancies] of have nothing to As of 6-16-17 at indicated she had the contracted p actual number of dispensed of iso Resident G. On 6-16-17 at I Nurse provided Emergency Me non-narcotic or did not include mg. On 6-16-17 at 4 provided a copy "Medications." date of 1-1-13 at 4 or 1-1-13 at 5 or 1-1-13 at 5	medication delivery , but was not limited to, ER 60 mg of 30 tablets. with the DON at this aned LPN #2 was told at very there was an issue nee coverage for this only 7 doses were cotics must be checked thers [non-narcotic e] have 24 hours to check thers [non-narcotic e] have 24 hours to check thers [non-narcotic e] have 24 hours to check there [non-narcotic e] have 26 hours to check ther					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155230	B. WING		06/16/2017	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP	CODE	
ROSEB	JD VILLAGE			CHESTER BLVD /IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	[×]	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC DATE
IAG	-	,	IAG	BLITCHLICET,		DATE
		cified, "Upon discovery				
		s an inadequate supply of administer to a resident,				
	-	ould immediately initiate				
		the medication from				
		medication shortage is				
		ng normal Pharmacy				
		nurse should call				
	-	termine the status of the				
		xt available delivery				
		a missed dose in the				
		cation schedule, Facility				
		otain the medication from				
		Medication Supply to				
		lose. If the medication is				
		the Emergency				
	-	pply, Facility staff should				
	-	y and arrange for an				
		very. If a medication				
	-	overed after normal				
	-	s: A licensed nurse				
		ne ordered medication				
	-	gency Medication Supply.				
		nedication is not available				
	-	cy Medication Supply, the				
		y nurse should call				
		ergency answering service				
	_	peak with the registered				
	-	luty to manage a plan of				
		may include: Emergency				
	-	of an emergency				
		l Party Pharmacy. If an				
		very is unavailable,				
	Facility should	contact the attending				

STATEMENT OF I		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 06/16/2017	
NAME OF PROVID	DER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	3	
ROSEBUD VII	LAGE				HESTER BLVD OND, IN 47374		
	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE
If the Phater of the Phater of the Phater of the Phater of the Phater of the Physical of the P	ne medication rmacy or a 7 not be supply nufacturer, F rnate Physic essary. If the vailable from nulary cove er clinical re- aborate with risician/Prese able therape sed dose is to se should do the explanation the MAR or ministration to esper Facili umentation owing infor circumstance rtage; A desponse upon ten."	tain orders or directions. on is unavailable from Third Party Pharmacy, and lied from the Facility should obtain cian/Prescriber orders, as ne medication is m Pharmacy due to rage, contraindicationor cason, Facility should n Pharmacy and criber to determine cutic alternativeWhen a unavoidable, Facility ocument the missed dose tion for such missed dose TAR [treatment record] and in the nurse's ty policy. Such should include the mation: A description of ces of the medication cription of Pharmacy's notification; and Action(s) g relates to Complaint N00230907 and					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING	<u>00</u>	COME	PLETED 6/2017
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COI	DE	
ROSEBL	JD VILLAGE			CHESTER BLVD IMOND, IN 47374		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION
TAG	483.90(h)(5)	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
⁼ 0465 SS=D Bldg. 00	SAFE/FUNCTIO TABLE ENVIRO (h) Other Enviror The facility must	mental Conditions provide a safe, functional, nfortable environment for				
	applicable Feder regulations, rega areas, and smok account non-smo Based on interv reviewed for en found the facilit	iew, 3 of 4 residents vironmental comfort ty to be too cool for their t. (Resident C, Resident J	F 0465	F 465 Safe/Functional/Sanitar ortable Environment	-	07/16/201
		Findings include:		The facility must provide functional, sanitary, and comfortable environment residents, staff and the p	t for	
	Resident C on 6 indicated the fa aware of concer being too cool a	with a family member of 5-13-17 at 4:52 p.m., she cility had been made rns of the resident's room at a recent care plan y said they would move				
	the beds around	, and that hasn't happened e air from blowing on her		What corrective action(be accomplished for those		
		ew with Resident J on		residents found to have	e been	
	finds the room a	p.m. She commented she and building temperatures		affected by the deficien	t	
		e some of the time," wear a jacket or sweater		practice.		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/16/2017	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR or use a lap blan 3. In an intervie 6-14-17 at 2:52 j "they keep it too me that is on blo queried about co in the facility. 4. In an intervie 6-13-17 at 12:50 resident rooms d room temperatur finds some resid other rooms. 5. In an intervie 6-16-17 at 2:53 j residents" will c at times. She fai residents made t	w with Resident K on p.m. he commented, cool for somebody like ood thinners," when omfortable temperatures w with CNA #7 on a.m., she indicated to not have individual re controls and that she ent rooms cooler than w with CNA #8 on p.m., she shared "some omplain about being cold iled to specify which	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) The facility will ensure that a comfortable and safe temperati is maintained in all areas, in accordance with Federal Regulations. Maintenance will conduct a che of Resident Area temperatures a regular basis and keep a temperature log for each room checked. Customer Care Representative will ask residents on daily care rounds if they have any concer in regards to the temperature of their room for a period of 4 wee and document accordingly on Customer Care forms and infor the ED, DNS, and/or Maintenance of any temperature concerns.	eck on ess ns of eks m	
				How other residents having the potential to be affected by same deficient practice will be identified and what corrective	e	

	T OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLI A. BUILDINC B. WING	e construction 6 <u>00</u>	СОМ	(X3) DATE SURVEY COMPLETED 06/16/2017	
NAME OF P	ROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP C	CODE		
DOSEDU	D VILLAGE) CHESTER BLVD HMOND, IN 47374			
<u> </u>							
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
				action will be taken.			
				All residents have the be affected. Maintenar conduct a check of Ro temperatures per hall f 4 weeks and keep a te log for each room chec ensure all rooms have checked.	nce will om for a total of emperature cked, to		
				Customer Care Repre- will ask residents on da rounds if they have an in regards to the temper their room for a period and document any cor accordingly on a CQI t to be turned in weekly weeks to the ED and in ED, DNS, and/or Main any temperature conce	aily care y concerns erature of of 4 weeks neerns tool that is for 4 nform the tenance of		
			What measures will b place or what system changes will be made ensure that the defici practice does not rec	ic e to ent			

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/16/2017
	ĒR	2050 C	HESTER BLVD	
SUMMARY (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	NCIES ID PROVIDER'S PLAN OF CORRECTION D BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		E COMPLE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			The facility will ensure that a comfortable and safe tempe	
			be monitored to ensure the	•
			for 4 weeks, once a week fo months, and monthly therea Results will be reviewed at	r 3 fter
			By what date the systemic changes will be completed 07/16/2017	
	OF CORRECTION PROVIDER OR SUPPLIE ID VILLAGE SUMMARY (EACH DEFICIE	OF CORRECTION IDENTIFICATION NUMBER: 155230 PROVIDER OR SUPPLIER ID VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING D. WI	OP CORRECTION DENTIFICATION NUMBER: A. BUILDING 00

DEPARTMENT OF HEAC CENTERS FOR MEDIC.							TED: 07/13/20 RM APPROVED B NO. 0938-0391
STATEMENT OF DE AND PLAN OF CORR		x1) provider/supplier/clia identification number: 155230	r í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/16/2017	
NAME OF PROVIDE		R	•	2050 C	ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD IOND, IN 47374	•	
	ACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 9999 Bldg. 00	4 DEDGON		E 0	200	E 9999 Personnel		07/16/2017
(s) Pr certif appli This by: Based the fa the ap to leg LPN defic adven unit o Findi Durin 6-16- was r curre state. docur the S indic	ied, or regi cable state state rule v d on interv acility faile ppropriate gally functi in the State ient practic rsely affect on which sl ngs include ng a review 17 at 10:43 reviewed. I nt LPN lice The file d mentation of tate of Indi	staff must be licensed, stered in accordance with laws or rules. vas not met as evidenced iew and record review, d to ensure one LPN had state licensure to be able on in the capacity of an e of Indiana. This we has the potential to all 26 residents on the ne worked. (LPN #1) e: of employee records on 5 a.m., the file of LPN #1 It indicated she had a ensure for an adjacent id not contain any of current licensure for ana, or an application to cess had been initiated for	F 99	999	F 9999 Personnel Professional Staff must be licensed, certified, or registered in accordance wit applicable state laws or rules What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. An audit of the license binder conducted to ensure all licens were active and appropriate. T CEC is maintaining the binder ensure all current employees licenses remain active and tha new employee's licenses are active and appropriate per	s. I n was es Fhe to	07/16/2017

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	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V 2) MUU T		NSTRUCTION	(X3) DATE SUR	O. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		00	COMPLETE	
		155230	B. WING		00	06/16/20	
JAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
ROSEBI	JD VILLAGE				IESTER BLVD DND, IN 47374		
							(115)
X4) ID REFIX		STATEMENT OF DEFICIENCIES		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		CAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	In an interview	with the Executive					
	Director (ED) o	n 6-16-17 at 3:42 p.m.,					
	· · ·	e had spoken to LPN #1.					
		PN #1 had attempted to					
	-	ate paperwork for the					
		e as an LPN, but there					
		type of problem and it			How other residents having	the	
	had not been rec	ceived by the Professional			potential to be affected by		
	Licensing Agen	cy.			same deficient practice will I		
	Review of I DN	#1's employment file			same dencient practice will i	Je	
		as employed on 5-3-2017.			identified and what correctiv	e	
		:02 p.m., the ED					
		of LPN #1's time record			action will be taken.		
		ated she had oriented at					
		-11-17, 6-5-17, 6-6-17,					
	-	and 6-9-17. It indicated			All residents had the potential	to	
		ing on 6-12-17 for 15.25			be affected.		
	-	nued working on 6-14-17			CEC will verify all licensures a	re	
		nd 6-15-17 for 8.25			active in the State of Indiana		
	hours.	nu 0-13-17 101 8.23			the PLA website. An in-service		
	nours.				Basic Leadership Training (hir		
	$O_{2} \in 16, 17 \text{ st} 4$	27 nm the Director of			practices, effective discipline, specific orientation program, e		
		:37 p.m., the Director of			will be conducted on July 19,		
		ed a copy of a document nnel and Confidential			2017 for all department heads	. A	
	· · · · ·				full HR Assessment on all		
		Checklist." This			Employees hired within the las months will be conducted on a		
		indated, but indicated to			7, 2017.	lary	
	-	rocedure utilized by					
		tes to ensure all necessary					
		was present for each					
		This document identified					
		have the "Professional			What measures will be put in	ito	
		fication Verification,"					
	present prior to	new hire orientation for			place or what systemic		

	T OF DEFICIENCIES	IVIN DDAV/INED/SLIDDI IED/CLIA			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u>00</u>	COMPLETED
		155230	B. WING		06/16/2017
NAME OF F	ROVIDER OR SUPPLIEI	2		ADDRESS, CITY, STATE, ZIP CODE	
	ID VILLAGE			HESTER BLVD IOND, IN 47374	
				IOND; IN 47374	
X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	any employee that required a license or			changes will be made to	
	certification for	employment.		changes will be made to	
				ensure that the deficient	
	This State tag re	lates to Complaint			
	IN00226575.			practice does not recur.	
	3.1-14(s)				
				All new hires will have licensures	
				checked and verified for the state	
				of Indiana by the CEC via the	-
				PLA website.	
				How the corrective action will	
				be monitored to ensure the	
				deficient practice will not recur	
				The CEC will do a weekly audit of the Licensure binder x's 4 weeks and as needed thereafter.	
				By what date the systemic changes will be completed.	
				07/16/2017	

						PRIN	TED:	07/13/2017	
DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED		
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED			
		155230	B. WING			06/16/2017			
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		(X5) PLETION ATE	

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v ID: 000135