STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBUD 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00226575, IN00227190, IN00230907 and IN00232339. Complaint IN00226575 - Substantiated. Federal/State deficiencies related to the allegations are cited at F226, F329, F332, F354, F425 and F9999. Complaint IN00227190 - Substantiated. Federal/State deficiency related to the allegations is cited at F354. Complaint IN00230907 - Substantiated. Federal/State deficiencies related to the allegations are cited at F312, F329, F332, F354 and F425. Complaint IN00232339 - Substantiated. Federal/State deficiencies related to the allegations are cited at F332, F354, F425 and F465. Survey dates: June 12, 13, 14, 15 and 16, 2017 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type:	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Included all auditing tools and policies used for in-servicing as attachments Placed deficiency coding on each attachment for reference. Due to relative low scope and severity, the provider respectfully asks for a desk review in lieu of a post survey revisit.	

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

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	SNF/NF: 87 SNF: 4 Total: 91 Census Payor Type: Medicare: 7 Medicaid: 60 Other: 24 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 26, 2017			
F 0226 SS=E Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (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,			

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	and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.			
	Based on interview and record review, the facility failed to ensure 5 of 5 employees employed within the last 120 days had a minimum of two references checked prior to employment with the facility. (LPN #1, CNA #3, CNA #4, CNA #5, and MCF (Memory Care Facilitator) #6). Findings include: During review of employee records on 6-16-17 at 10:45 a.m., of employees hired within the last 120 days, 4 of 5 employees, LPN #1, CNA #3, CNA #4, and CNA #5 had no documentation of any reference checks conducted from previous employers or personal references prior to employment, with 1 of 5 employees, MCU #6, having one reference check document prior to employment.	F 0226	**F 226 Develop/Implement Abuse/Neglect, ETC. Policies** **What corrective action(s) will be** **accomplished for those** **residents found to have been** **affected by the deficient** **practice.** All staff to be educated/in-serviced on Abuse Prohibition, Reporting, and Investigation Policy and	07/16/2017

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	In an interview with the Executive Director on 6-16-17 at 12:30 p.m., she explained, "As you know, we had several positions open, including our CEC [Clinical Education Coordinator], who normally checks new employee's references. We recently discovered several people were employed without reference checks being done." On 6-13-17 at 1:30 p.m., the Director of Nursing provided a copy of a policy entitled, "Abuse Prohibition, Reporting and Investigation." This policy has a revision date of 11-2016 and was identified to be the policy currently utilized by the facility. This policy stipulated, "It is the policy of [name of corporation] to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, misappropriation of resident property and/or funds, and any physical/chemical restraint not required to treat the resident's medical symptoms...Employment screening is done on all potential employees..." On 6-16-17 at 4:37 p.m., the Director of Nursing provided a copy of a document entitled, "Personnel and Confidential Employee File Checklist." This document was undated, but indicated to		Procedure. ED or Designee to 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. **How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. All staff to be educated/in-serviced on Abuse Prohibition, Reporting, and	

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	be the current procedure utilized by Human Resources to ensure all necessary documentation was present for each employee file. This document identified each file should have a minimum of two reference checks conducted prior to new hire orientation. This Federal tag relates to Complaint IN00226575. 3.1-14(a)		Investigation Policy and Procedure. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** 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	

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			How the corrective action will be monitored to ensure the deficient practice will not recur. HR will not continue with orientation or the hiring process until all areas have been completed. HR and CEC will work together to ensure all back-ground checks, reference checks, TB tests, and drug screens have been completed prior to orientation or job offer. **By what date the systemic changes will be completed.** 07/16/2017	
F 0312 SS=D Bldg. 00	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure 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 residing on the memory care unit, reviewed for cleanliness. (Resident C, Resident D and Resident E) Findings include: 1. The clinical record of Resident C was reviewed on 6-13-17 at 2:25 p.m. Her diagnoses included, but were not limited to, dementia, general muscle weakness and metabolic encephalopathy. It indicated she resided on the memory care unit of the facility since admission, over three years ago. Review of her most recent Minimum Data Set (MDS) assessment, dated 3-4-17, indicated she is moderately cognitively impaired, requires extensive assistance of one person for hygiene services and is dependent of one person for bathing services. It indicated she uses a walker for mobility with limited assistance of one person. The memory care unit's bathing calendar indicated Resident C was to receive a shower or complete bed bath twice	F 0312	**F312 ADL Care provided for dependent residents** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** POC documentation was reviewed for resident C, D, and E for accuracy. Showers and/ or bed baths were provided as indicated. Residents will be showered/complete bed bath twice weekly or per preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Audit will be completed by Activities/MCF/designee of preferences for showers for residents by July 16, 2017. Shower schedules will be adjusted as indicated by July 16, 2017. Preferences will be assessed upon admission, annually with MDS schedule and when requested by resident, family, guardian or POA. Shower sheets and POC documentation will be reviewed for accuracy by 7/16/17 and addressed as indicated. **What measures will be put into**	07/16/2017

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	weekly on the night shift of each Monday and Thursday. Review of the facility's "Point of Care" electronic documentation for bathing for May and June, 2017, indicated Resident C received a shower or complete bed bath on 5-1-17, on the night and evening shift, 5-2-17, on evening shift, 5-4-17, on night shift, 5-8-17, on night shift, 5-11-17, on night shift, 5-15-17, on night shift, 5-18-17, on night shift and 6-12-17, on night shift. Review of the corresponding shower reports, completed by hand, for the same time period, indicated Resident C received a shower or complete bed bath on 5-1-17, 5-4-17, 5-11-17, 5-15-17, 5-18-17, 5-27-17, 6-1-17, 6-4-17, 6-8-17, 6-10-17 and 6-12-17. In an interview with a family member of Resident C on 6-13-17 at 4:52 p.m., she shared, "I know she is supposed to get a shower twice a week, on evening shift. I'm not sure she even gets one a week...Overall, she seems fairly clean." In interview with the Director of Nursing on 6-15-17 at 1:30 p.m., she indicated the staff are expected to document on the computer and the handwritten "shower sheets," with the documentation between		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Re-education will be provided for nursing on accurate documentation of showers in POC and use of shower sheets by 7/16/17. Certified nursing assistants to have a shower skills validation completed by July 16, 2017. RAI specialist to do ADL coding re-education with nursing staff by July 16, 2017. DNS/Designee will track shower sheets a minimum of weekly to ensure showers/complete bed baths are given per assigned schedule. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/designee is responsible for the completion of the Accommodation of needs QAPI tool weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary	

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	the electronic version and handwritten version being consistent. 2. The clinical record of Resident D was reviewed on 6-13-17 at 12:45 p.m. His diagnoses included, but were not limited to, Alzheimer's disease, difficulty walking and general muscle weakness. It indicated he resided on the memory care unit of the facility for over one year. Review of his most recent Minimum Data Set (MDS) assessment, dated 3-1-17 indicated he is severely cognitively impaired, requires extensive assistance of two or more persons for hygiene services and is dependent of two or more persons for bathing services. It indicated he uses a walker for mobility with supervision assistance of one person. Review of the facility's "Point of Care" electronic documentation for bathing for April and May, 2017, indicated Resident D received a shower or complete bed bath on 4-3-17, 4-5-17, 4-7-17, 4-9-17, 4-12-17, 4-14-17, 4-16-17, 4-18-17, 4-21-17, twice on 4-24-17, 4-25-17, 5-1-17, 5-2-17, twice on 5-4-17, 5-16-17, 5-19-17, 5-22-17, and 5-26-17. Review of the corresponding shower reports, completed by hand, for the same time period, indicated Resident D received a shower or complete bed bath		action taken as needed.	

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	on 4-3-17, 4-5-17, 4-7-17, 4-12-17, 4-16-17, 5-2-17, 5-4-17, 5-5-17, 5-7-17 and 5-12-17. In an interview with a family member of Resident D on 6-13-17 at 2:59 p.m., she stated he had "Went for 1 and 1/2 weeks without shower or shaved...Would find him soaking wet or dirty on a regular basis, even with the Depends on. So I would just clean him up myself." She shared that she had met with Director of Nursing and the Administrator to discuss her concerns regarding Resident D, but elected to move him to another nursing facility recently. In interview with the Director of Nursing on 6-15-17 at 1:30 p.m., she indicated the 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. 3. The clinical record of Resident E was reviewed on 6-14-17 at 12:40 p.m. His diagnoses included, but were not limited to, dementia with behavioral disturbances and Parkinson's disease. It indicated he resided on the memory care unit of the facility since admission, nearly three years ago. Review of his most recent Minimum Data Set (MDS) assessment,			

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	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			

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	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 SS=D Bldg. 00	483.45(d) DRUG REGIMEN IS FREE FROM 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. Based on observation, interview and record review, the facility failed to	F 0329	**F329 Drug Regimen is Free from Unnecessary Drugs**	07/16/2017

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	conduct routine monitoring of blood pressure assessments related to the use of antihypertensive medications for 2 of 3 residents reviewed for medication accuracy. (Resident F and Resident G) Findings include: 1. The clinical record of Resident F was reviewed on 6-15-17 at 2:15 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: hydrochlorothiazide (a diuretic), 25 milligrams (mg) daily by mouth. -lisinopril-hydrochlorothiazide (a combination product of a blood pressure medication and a diuretic for blood pressure control) 20/25 mg daily by mouth,"Start after supply of 20 mg is complete." -bisoprolol fumarate (used for heart and/or blood pressure issues) 5 mg daily by mouth. In review of the physician orders, an order, dated 4-6-17, stipulated to start lisinopril-hydrochlorothiazide 20/25 mg daily by mouth upon completion of the lisinopril supply of 20 mg. There was not a follow up clarification physician's		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Orders were obtained for resident F and G to obtain blood pressure before administration of medication, with hold parameters as indicated and to notify physician when indicated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Audit of all MARS was completed on June 16, 2017 and orders were obtained for blood pressure monitoring with parameters in place for residents receiving Antihypertensive medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DNS/Designee will re-educate nurses on monitoring blood pressures before administering hypertensive medications and notification of MD/ and or holding medication if indicated when BP out of range by 7/16/17. DNS/designee will ensure that all new orders for hypertensive medications have proper orders	

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	order to specify to continue the hydrochlorothiazide 25 milligrams daily by mouth in addition to the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth. Review of the MAR (medication administration record) for May and June, 2017, indicated both the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth and the hydrochlorothiazide 25 milligrams daily by mouth were administered 5-1-17, through 5-31-17, and 6-1-17, through 6-15-17. The bisoprolol fumarate 5 mg daily by mouth was documented as administered 5-1-17, through 5-31-17, and 6-1-17, through 6-15-17. In review of documented blood pressure checks for Resident F for the time period 4-1-17 to 6-15-17, the following blood pressure readings were present in the clinical record: -4-6-17: 138/76. -4-7-17: 129/67. -4-8-17: 150 /70 -4-9-17: 148/66. -4-22-17: 129/69. -5-20-17: 114/61. -6-7-17: 111/61. -6-8-17: 144/58. -6-10-17: 138/84.		with parameters in place and all nurses/QMA's will complete a medication pass procedure validation by July 16, 2017. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/designee is responsible for the completion of the Assessment with Antihypertensive QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	155230	A. BUILDING 00 B. WING	06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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	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			

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	administration record) for May and June, 2017, it specified the metoprolol tartrate 25 mg daily by mouth was administered 5-27-17 through 6-6-17 and 6-8-17 through 6-15-17, with one missed dose on 6-7-17. This missed dose had an empty documentation block, with no initials or explanation for the reason it was not administered. The isosorbide MN ER 60 mg daily by mouth was ordered effective of 5-26-17, and was administered on 5-29-17, 5-30-17, 5-31-17, 6-2-17, 6-4-17, 6-7-17, 6-8-17, 6-9-17, 6-10-17, 6-11-17, and 6-12-17. The MAR specified this medication was 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 to 6-15-17 at 10:00 a.m., failed to document any notification to the physician of blood pressure medications being unavailable. In review of documented blood pressure checks for Resident G for the time period			

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	5-26-17 to 6-15-17, the following blood pressure readings were present in the clinical record: -5-26-17: 141/83. 5-27-17: 106/63 and 108/73. 5-28-17: 117/66. 5-29-17: 107/67. 5-30-17: 117/63. 6-2-17: 116/67. 6-4-17: 124/68. 6-6-17: 172/76. 6-8-17: 129/77. 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. This Federal tag relates to Complaint IN00226575 and Complaint IN00230907. 3.1-48(a)(3)			
F 0332 SS=E Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to ensure	F 0332	**F332 Free from medication error rates of 5% or more**	07/16/2017

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	it was free of a medication error rate of greater than 5 percent (%) for 2 of 8 residents observed during medication pass. Six medication errors were observed during 31 opportunities for error in medication administration. This resulted in a 19.3% medication error rate. (Resident F and Resident G) Findings include: 1. During a medication administration observation on 6-15-17 at 8:52 a.m., for Resident F with LPN #1, LPN #1 was observed to prepare the following medications: -Ocuvite Adult 50+ Softgel (a multi-vitamin), one softgel, daily by mouth. -hydrochlorothiazide (a diuretic), 25 milligrams (mg) daily by mouth. -lisinopril-hydrochlorothiazide (a combination product of a blood pressure medication and a diuretic for blood pressure control) 20/25 mg daily by mouth. "Start after supply of 20 mg is complete." -Loratadine (used for allergy control) 10 mg daily by mouth. -methimazole (used for hyperthyroidism) 5 mg daily by mouth. -Namenda XR (used for dementia) 28 mg daily by mouth. -potassium (supplement) ER 20 millequivalents daily by mouth.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Physician and Pharmacy notified of medications needed. Medications were administered as indicated. Hold orders were obtained as appropriate. Resident assessments were completed as indicated for resident F and G **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 deficient practice. An audit will be completed by Omnicare by July 16, 2017 to ensure all ordered medications are available for administration. Medications will be obtained if indicated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Pharmacy to audit resident's medications to ensure medications are available for administration by July 16, 2017. All nurses/QMA's will be	

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	-Flonase (allergy medication) 50 micrograms (mcg) one spray in each nostril daily. Upon preparing the above medications, LPN #1 was observed to administer the medications to Resident F. After the administration of these medications, LPN #1 shared she was unsure of the equivalency of Ocuvite and Cerovite. At 9:58 a.m., she shared that she was unable to administer several medications that she could not locate, specifically the following medications: -bisoprolol fumarate (used for heart and/or blood pressure issues) 5 mg daily by mouth. -vitamin B-12 (supplement) 1000 mcg daily by mouth. -Caltrate 600 mg with (vitamin supplement) D-3 and minerals (supplement) once daily by mouth. -Cerovite Advanced Formula (vitamin supplement) once daily by mouth. LPN #1 was then observed to locate several of the medications, specific to Caltrate 600 mg with (Vitamin) D-3 and minerals, vitamin B-12 and bisoprolol fumarate, and those were administered between 10:00 a.m., and 10:15 a.m. The administration time listed for each of these medications was listed as 8:00 a.m. She was unable to locate the Cerovite		re-educated on medication pass and steps to take when a mediation is unavailable by 7/16/17 by DNS or designee. CEC/ designee will complete a Medication Administration Skills Validation with nurses and QMAs by 7/16/17. All new hire Nurses and QMAs will be checked off on the Medication Administration Skills validation tool by CEC or designee prior to working on the floor independently. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee will observe 5 medication passes using the Medication Administration Skills check off tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	Advanced Formula and it was not administered. In review of the physician orders, an order, dated 4-6-17, stipulated to start lisinopril-hydrochlorothiazide 20/25 mg daily by mouth upon completion of the lisinopril supply of 20 mg. There was not a follow up clarification physician's order to specify to continue the hydrochlorothiazide 25 milligrams daily by mouth in addition to the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth. Review of the MAR (medication administration record) for May and June, 2017, it indicated both the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth and the hydrochlorothiazide 25 milligrams daily by mouth were administered 5-1-17, through 5-31-17, and 6-1-17, through 6-15-17. 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			

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	acceptable boundaries." In review of the medication orders for Resident F, after the medication administration observation, an order for Ocuvite Adult 50+ Softgel could not be located on the recapitulation orders for June, 2017. In an interview with the Director of Nursing on 6-16-17 at 9:45 a.m., she clarified the order for this medication was discontinued on 5-11-17, by the physician, based upon recommendations from the pharmacy consultant on 5-9-17, as possible duplicate therapy of Ocuvite and Cerovite. The May and June, 2017, MAR indicated the daily dose of Ocuvite was administered 5-12-17, through 5-31-17, and on 6-15-17. 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 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			

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	(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. In review of the medication orders for Resident G, upon completion of the medication administration observation, the MAR (medication administration record) for May and June, 2017, was reviewed. It indicated the isosorbide MN ER 60 mg daily by mouth was ordered effective of 5-26-17 and was administered on 5-29-17, 5-30-17, 5-31-17, 6-2-17, 6-4-17, 6-7-17, 6-8-17, 6-9-17, 6-10-17, 6-11-17, and 6-12-17. The MAR specified this medication was			

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	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			

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	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			

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	nurse should obtain the medication from the Emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery. If a medication shortage is discovered after normal Pharmacy hours: A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage a plan of action. Action may include: Emergency delivery or Use of an emergency (back-up) Third Party Pharmacy. If an emergency delivery is unavailable, Facility should contact the attending physician to obtain orders or directions. If the medication is unavailable from Pharmacy or a Third Party Pharmacy, and cannot be supplied from the manufacturer, Facility should obtain alternate Physician/Prescriber orders, as necessary. If the medication is unavailable from Pharmacy due to formulary coverage, contraindication...or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine			

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	suitable therapeutic alternative...When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR [treatment administration record] and in the nurse's notes per Facility policy. Such documentation should include the following information: A description of the circumstances of the medication shortage; A description of Pharmacy's response upon notification; and Action(s) taken." This Federal tag relates to Complaint IN00226575, IN00230907 and IN00232339. 3.1-25(b)(9) 3.1-48(c)(1)			
F 0354 SS=E Bldg. 00	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (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. (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.			

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	(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 eight consecutive hours of RN staffing on a daily basis for the facility. This deficient practice has the potential to negatively impact the care and services of all 91 residents in the facility. Findings include: Review of the posted staffing on 6-13-17 at 12:45 a.m., demonstrated the posted dates for 6-8-17 and 6-9-17, reflected no RN coverage on those dates for those 24 hour periods. Review of the posted staffing on 6-13-17 at 1:35 p.m., demonstrated the posted dates for 6-12-17 and 6-13-17, reflected no RN coverage on those dates for those 24 hour periods. In an interview on 6-13-17 at 1:30 p.m., with the Director of Nursing (DON), she commented, "We currently do not have any RN coverage, except for myself, the ADON (Assistant Director of Nursing) and the CEC (Clinical Education Coordinator)." On 6-14-17 at 11:05 a.m., the DON provided copies of the time records for	F 0354	**F 354 RN 8 hours/ 7 days a week, full time DON** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Facility has hired two RN charge nurses who are currently in orientation. Rotation of nurse management staff to ensure RN coverage by July 16, 2017. Full time DON on staff. **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 have the potential to be affected by this deficient practice. DNS/designee will work with scheduler to ensure 8-hour RN coverage is obtained and Nurse Management rotation to be implemented to ensure 8-hour RN coverage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	07/16/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBUD 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
	herself, the ADON and the CEC for the dates 5-28-17 through 6-14-17. The DON clarified the CEC had been on orientation the prior week of 6-4-17 through 6-10-17, beginning her official duties on 6-12-17. In review of the time records of the ADON for 5-28-17 through 6-13-17, it indicated she was not working on 5-28-17, 5-29-17, 6-3-17, 6-4-17, 6-10-17, 6-11-17, and 6-12-17. Additionally, on 6-2-17, her time record reflected she was working only 7 hours. This Federal tag relates to Complaint IN00226575, IN00227190, Complaint IN00230907 and IN00232339. 3.1-17(b)(1) 3.1-17(b)(3) 3.1-17(e)		**practice does not recur?** DNS/designee will oversee schedule in advance to ensure 8-hour RN coverage is maintained by July 16, 2017. DNS will initiate a nurse management rotation to ensure 8-hour RN coverage is maintained by July 16, 2017. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the RN Coverage QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.	
F 0425 SS=D Bldg. 00	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate			

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	acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; Based on observation, interview and record review, the facility failed to ensure ordered medications were available and administered at the appropriate time, any physician orders were clarified to prevent errors or duplication of medications and pharmacy consultations included review of potential duplication of medications for 2 of 3 residents reviewed for medication accuracy. (Resident F and Resident G) Findings include: 1. During a medication administration observation on 6-15-17 at 8:52 a.m., for Resident F with LPN #1, LPN #1 was observed to prepare the following medications: -Ocuvite Adult 50+ Softgel (a multi-vitamin), one softgel, daily by mouth. -hydrochlorothiazide (a diuretic), 25 milligrams (mg) daily by mouth. -lisinopril-hydrochlorothiazide (a	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 unavailable 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 that 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	07/16/2017

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	combination product of a blood pressure medication and a diuretic for blood pressure control) 20/25 mg daily by mouth. "Start after supply of 20 mg is complete." -Loratadine (used for allergy control) 10 mg daily by mouth. -methimazole (used for hyperthyroidism) 5 mg daily by mouth. -Namenda XR (used for dementia) 28 mg daily by mouth. -potassium (supplement) ER 20 millequivalents daily by mouth. -Flonase (allergy medication) 50 micrograms (mcg) one spray in each nostril daily. Upon preparing the above medications, LPN #1 was observed to administer the medications to Resident F. After the administration of these medications, LPN #1 shared she was unsure of the equivalency of Ocuvite and Cerovite. At 9:58 a.m., she shared that she was unable to administer several medications that she could not locate, specifically the following medications: -bisoprolol fumarate (used for heart and/or blood pressure issues) 5 mg daily by mouth. -vitamin B-12 (supplement) 1000 mcg daily by mouth. -Caltrate 600 mg with (vitamin supplement) D-3 and minerals		medications currently ordered to ensure medications are available for administration by July 17, 2017. Medications will be obtained as indicated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** 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 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. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Pharmacy Services QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results	

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	(supplement) once daily by mouth. -Cerovite Advanced Formula (vitamin supplement) once daily by mouth. LPN #1 was then observed to locate several of the medications, specific to Caltrate 600 mg with (Vitamin) D-3 and minerals, vitamin B-12 and bisoprolol fumarate, and those were administered between 10:00 a.m., and 10:15 a.m. The administration time listed for each of these medications was 8:00 a.m. She was unable to locate the Cerovite Advanced Formula and it was not administered. In review of the physician orders, an order, dated 4-6-17, stipulated to start lisinopril-hydrochlorothiazide 20/25 mg daily by mouth upon completion of the lisinopril supply of 20 mg. There was not a follow up clarification physician's order to specify to continue the hydrochlorothiazide 25 milligrams daily by mouth in addition to the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth. Review of the MAR (medication administration record) for May and June, 2017, it indicated both the lisinopril-hydrochlorothiazide 20/25 mg daily by mouth and the hydrochlorothiazide 25 milligrams daily by mouth were administered 5-1-17, through 5-31-17, and 6-1-17, through 6-15-17.		of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	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." In review of the medication orders for Resident F, after the medication administration observation, an order for Ocuvite Adult 50+ Softgel could not be located on the recapitulation orders for June, 2017. In an interview with the Director of Nursing on 6-16-17 at 9:45 a.m., she clarified the order for this medication was discontinued on 5-11-17, by the physician, based upon recommendations from the pharmacy consultant on 5-9-17, as possible duplicate therapy of Ocuvite and Cerovite. The May and June, 2017, MAR indicated the daily dose of Ocuvite was administered 5-12-17, through 5-31-17, and on 6-15-17. On 6-16-17 at 10:00 a.m., the Corporate Nurse provided a listing of the current			

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	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.			

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	In review of the medication orders for Resident G, upon completion of the medication administration observation, the MAR (medication administration record) for May and June, 2017, was reviewed. It indicated the isosorbide MN ER 60 mg daily by mouth was ordered effective of 5-26-17 and was administered on 5-29-17, 5-30-17, 5-31-17, 6-2-17, 6-4-17, 6-7-17, 6-8-17, 6-9-17, 6-10-17, 6-11-17, and 6-12-17. The MAR specified this medication was 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 medications 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			

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	#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 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.			

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	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 nurse should obtain the medication from the Emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery. If a medication shortage is discovered after normal Pharmacy hours: A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage a plan of action. Action may include: Emergency delivery or Use of an emergency (back-up) Third Party Pharmacy. If an emergency delivery is unavailable, Facility should contact the attending			

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	physician to obtain orders or directions. If the medication is unavailable from Pharmacy or a Third Party Pharmacy, and cannot be supplied from the manufacturer, Facility should obtain alternate Physician/Prescriber orders, as necessary. If the medication is unavailable from Pharmacy due to formulary coverage, contraindication...or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine suitable therapeutic alternative...When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR [treatment administration record] and in the nurse's notes per Facility policy. Such documentation should include the following information: A description of the circumstances of the medication shortage; A description of Pharmacy's response upon notification; and Action(s) taken." This Federal tag relates to Complaint IN00226575, IN00230907 and IN00232339. 3.1-25(a) 3.1-25(e)(1)			

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F 0465 SS=D Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on interview, 3 of 4 residents reviewed for environmental comfort found the facility to be too cool for their level of comfort. (Resident C, Resident J and Resident K) Findings include: 1. In interview with a family member of Resident C on 6-13-17 at 4:52 p.m., she indicated the facility had been made aware of concerns of the resident's room being too cool at a recent care plan meeting. "They said they would move the beds around, and that hasn't happened yet... to keep the air from blowing on her directly." 2. In an interview with Resident J on 6-14-17 at 2:38 p.m. She commented she finds the room and building temperatures "too cool for me some of the time," requiring her to wear a jacket or sweater	F 0465	**F 465** **Safe/Functional/Sanitary/Comfortable Environment** The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **What corrective action(s) will be** **accomplished for those** **residents found to have been** **affected by the deficient** **practice.**	07/16/2017

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	or use a lap blanket. 3. In an interview with Resident K on 6-14-17 at 2:52 p.m. he commented, "they keep it too cool for somebody like me that is on blood thinners," when queried about comfortable temperatures in the facility. 4. In an interview with CNA #7 on 6-13-17 at 12:50 a.m., she indicated resident rooms do not have individual room temperature controls and that she finds some resident rooms cooler than other rooms. 5. In an interview with CNA #8 on 6-16-17 at 2:53 p.m., she shared "some residents" will complain about being cold at times. She failed to specify which residents made this complaint. This Federal tag relates to Complaint IN00232339. 3.1-19(h)		The facility will ensure that a comfortable and safe temperature is maintained in all areas, in accordance with Federal Regulations. Maintenance will conduct a check of Resident Area temperatures on a regular basis and keep a temperature log for each room checked. Customer Care Representatives will ask residents on daily care rounds if they have any concerns in regards to the temperature of their room for a period of 4 weeks and document accordingly on Customer Care forms and inform the ED, DNS, and/or Maintenance of any temperature concerns. **How other residents having the potential to be affected by same deficient practice will be identified and what corrective**	

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			action will be taken. All residents have the potential to be affected. Maintenance will conduct a check of Room temperatures per hall for a total of 4 weeks and keep a temperature log for each room checked, to ensure all rooms have been checked. Customer Care Representatives will ask residents on daily care rounds if they have any concerns in regards to the temperature of their room for a period of 4 weeks and document any concerns accordingly on a CQI tool that is to be turned in weekly for 4 weeks to the ED and inform the ED, DNS, and/or Maintenance of any temperature concerns. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	

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			The facility will ensure that a comfortable and safe temperature is maintained in all areas, in accordance with Federal Regulations. **How the corrective action will** **be monitored to ensure the** **deficient practice will not recur.** CQI tool for resident room temperature logs tests to be completed 5x weekly for 4 weeks, once a week for 3 months, and monthly thereafter Results will be reviewed at Continuous Quality Improvement Meeting. **By what date the systemic** **changes will be completed.** 07/16/2017	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure one LPN had the appropriate state licensure to be able to legally function in the capacity of an LPN in the State of Indiana. This deficient practice has the potential to adversely affect all 26 residents on the unit on which she worked. (LPN #1) Findings include: During a review of employee records on 6-16-17 at 10:45 a.m., the file of LPN #1 was reviewed. It indicated she had a current LPN licensure for an adjacent state. The file did not contain any documentation of current licensure for the State of Indiana, or an application to indicate the process had been initiated for Indiana licensure.	F 9999	**F 9999 Personnel** **Professional Staff must be licensed, certified, or registered in accordance with 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 was conducted to ensure all licenses were active and appropriate. The CEC is maintaining the binder to ensure all current employees licenses remain active and that all new employee's licenses are active and appropriate per guidelines.	07/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	06/16/2017

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	In an interview with the Executive Director (ED) on 6-16-17 at 3:42 p.m., she indicated she had spoken to LPN #1. She explained LPN #1 had attempted to file the appropriate paperwork for the Indiana licensure as an LPN, but there had been some type of problem and it had not been received by the Professional Licensing Agency. Review of LPN #1's employment file indicated she was employed on 5-3-2017. On 6-16-17 at 4:02 p.m., the ED provided a copy of LPN #1's time record which demonstrated she had oriented at the facility on 5-11-17, 6-5-17, 6-6-17, 6-7-17, 6-8-17 and 6-9-17. It indicated she began working on 6-12-17 for 15.25 hours, and continued working on 6-14-17 for 8.25 hours and 6-15-17 for 8.25 hours. On 6-16-17 at 4:37 p.m., the Director of Nursing provided a copy of a document entitled, "Personnel and Confidential Employee File Checklist." This document was undated, but indicated to be the current procedure utilized by Human Resources to ensure all necessary documentation was present for each employee file. This document identified each file should have the "Professional Licensure/Certification Verification," present prior to new hire orientation for		**How other residents having the potential to be affected by same deficient practice will be identified and what corrective action will be taken.** All residents had the potential to be affected. CEC will verify all licensures are active in the State of Indiana via the PLA website. An in-service on Basic Leadership Training (hiring practices, effective discipline, job specific orientation program, etc.) will be conducted on July 19, 2017 for all department heads. A full HR Assessment on all Employees hired within the last 6 months will be conducted on July 7, 2017. **What measures will be put into place or what systemic**	

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	any employee that required a license or certification for employment. This State tag relates to Complaint IN00226575. 3.1-14(s)		**changes will be made to ensure that the deficient practice does not recur.** 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	

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