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| | 155721 | A. BUILDING 00<br>B. WING | 04/29/2019 |

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| LAWRENCE MANOR HEALTHCARE CENTER | 8935 E 46TH ST<br>INDIANAPOLIS, IN 46226 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: April 22, 23, 24, 25, 26, and 29, 2019<br><br>Facility number: 000383<br>Provider number: 155721<br>AIM number: 100289610<br><br>Census Bed Type:<br>SNF/NF: 27<br>SNF: 27<br>Total: 27<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 22<br>Other: 1<br>Total: 1<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 10, 2019 | F 0000 | Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 5-29-19, to the Annual State Survey conducted 4-29-19. | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>Based on observation, interview, and record review, the facility failed to ensure a call light was in reach for 1 of 1 residents reviewed for call light. | F 0558 | F558<br>1) The call light for resident 14 was extended and provided within | 05/29/2019 |

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

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| | (Resident 14)<br><br>Findings include:<br><br>The clinical record for Resident 14 was reviewed on 4/29/18 at 2:00 p.m. The diagnoses for Resident 14 included, but were not limited to, renal disorder and dementia.<br><br>The 3/10/19 Admission MDS (Minimum Data Set) assessment indicated Resident 14 had a functional status of extensive assistance with 1 person assist in bed mobility and locomotion on unit. She had extensive assistance with 2 person assistance for transfers.<br><br>An observation was made of Resident 14 on 4/22/19 at 11:06 a.m. Resident 14 was sitting in her wheelchair by the bed. The call light cord was attached to the wall and dangled down the length of the wall past the mattress of the bed. The call light was not observed in reach of Resident 14.<br><br>An observation was made of Resident 14 on 4/29/19 at 11:00 a.m. The call light cord was observed hanging down the wall by the bed. The call light was located opposite of the side of bed from where Resident 14 was sitting in her wheelchair.<br><br>An interview was conducted with Resident 14 at 4/29/19 at 11:02 a.m. She indicated she could not reach her call light where it was located.<br><br>During an environmental tour with the Maintenance Housekeeping Supervisor on 4/29/19 at 11:05 a.m., he indicated the call light cord was not long enough to reach Resident 14.<br><br>An "Answering the Call light" policy was | | reach of resident 14 as soon as it was called to the facility's attention.<br><br>2) The call lights in all resident rooms were checked for accessibility and function with no corrective action needed.<br><br>3) All staff were inserviced on 5-2-19 ensuring residents have access to a call light within reach as a means of summoning assistance while in their room. Maintenance has noted the weekly inspection of call light accessibility and function in the TELS preventative maintenance program.<br><br>4) Maintenance will monitor accessibility and function weekly for six months and ongoing and document findings on the TELS/PM log. The Director of Nursing or designee will monitor call light within reach while resident is in room by making observation rounds three times weekly (one on each shift) for six months and document findings on Call Light Audit Form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | provided by the Region Administrator on 4/29/19 at 12:00 p.m. It indicated "...Purpose. The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines. 1. Explain the call light to the new resident. 2. Demonstrate the use of the call light. 3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system...4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident..."<br><br>3.1-3(v)(1) | | | |
| F 0582 SS=B Bldg. 00 | 483.10(g)(17)(18)(i)-(v)<br>Medicaid/Medicare Coverage/Liability Notice<br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any | | | |

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| | charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. | | | |
| | Based on interview and record review, the facility failed to issue SNFABN (Skilled Nursing Facility Advanced Beneficiary Notices) to 3 of 3 residents reviewed for beneficiary notices. (Residents 6, 20, and 24)<br><br>Findings include:<br><br>1. The SNF Beneficiary Protection Notification | F 0582 | F582<br>1) Although residents 6, 20 and 24 received the Notice of Medicare Non-Coverage forms, A notation was placed in the files of residents 6, 20 and 24 indicating the SNFABN forms were not issued timely and reissued. | 05/29/2019 |

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| | Review form and NOMNC (Notice of Medicare Non Coverage) for Resident 20 were provided by the Region Administrator on 4/26/19 at 11:30 a.m. The NOMNC indicated covered services would end on 2/8/19 and was signed by Resident 20 on 2/4/19. The SNF Beneficiary Protection Notification Review form indicated the provider initiated the discharge from Medicare Part A Services, when benefit days were not exhausted, and that no SNFABN was provided to Resident 20, but with no explanation as to why it was not provided.<br><br>An interview was conducted with the Region Administrator on 4/26/19 at 11:30 a.m. He indicated Resident 20 should have been issued a SNF ABN, but was not.<br><br>2. The SNF Beneficiary Protection Notification Review form and NOMNC (Notice of Medicare Non Coverage) for Resident 24 were provided by the Region Administrator on 4/26/19 at 11:30 a.m. The NOMNC indicated covered services would end on 12/18/19 and was signed by Resident 24 on 12/11/19. The SNF Beneficiary Protection Notification Review form indicated the provider initiated the discharge from Medicare Part A Services, when benefit days were not exhausted, and that no SNFABN was provided to Resident 20, but with no explanation as to why it was not provided.<br><br>An interview was conducted with the Region Administrator on 4/26/19 at 11:30 a.m. He indicated Resident 24 should have been issued a SNFABN, but was not.<br><br>3. The SNF Beneficiary Protection Notification Review form and NOMNC (Notice of Medicare Non Coverage) for Resident 6 were provided by | | 2) The resident files of all Medicare beneficiaries were audited and SNFABN forms were issued as needed.<br><br>3) SNFABN forms will be included in the admission packet and issued at the time of admission to Medicare beneficiaries when services usually paid by Medicare are not covered because they are not medically reasonable or necessary; or considered custodial care. The Business Office Manager was inserviced on 5-10-19 regarding the issuance of the SNFABN form.<br><br>4) The Administrator will monitor by auditing the completed business-related admission paperwork within 72-hours of admission for all new admission and hospital readmissions for six months; and findings will be documented on the Business Office Admission Readmission Checklist. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | the Region Administrator on 4/26/19 at 11:30 a.m. The NOMNC indicated covered services would end on 2/4/19 and was signed by Resident 6 on 2/4/19. The SNF Beneficiary Protection Notification Review form indicated the provider initiated the discharge from Medicare Part A Services, when benefit days were not exhausted, and that no SNF ABN was provided to Resident 20, but with no explanation as to why it was not provided.<br><br>An interview was conducted with the Region Administrator on 4/26/19 at 11:30 a.m. He indicated Resident 20 should have received a 2 day notice regarding her NOMNC and should have been issued a SNF ABN, but was not.<br><br>The Region Administrator provided the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) on 4/26/19 at 11:30 a.m. It read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A)."<br><br>3.1-4(f)(3) | | | |
| F 0600<br>SS=E<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and | | | |

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| | Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse for 5 of 8 residents reviewed for abuse. (Residents 6, 7, 19, 5 and 20)<br><br>Findings include:<br><br>1a. The clinical record for Resident 6 was reviewed on 4/24/19 at 12:00 p.m. The diagnoses for Resident 6 included, but were not limited to, bipolar disorder and anxiety.<br><br>An interview was conducted with Resident 6 on 4/24/19 at 11:05 a.m. She indicated Resident 19 yelled at her in the dining room, couldn't remember exactly what he said, but remembered it did not make her feel good.<br><br>The 2/5/19 Social Service Alert form for Resident 19, written by COTA (Certified Occupational Therapy Assistant) 6, indicated Resident 19 was verbally aggressive, socially inappropriate/disruptive, and used profanities towards Resident 6. It read, "In dinning (sic) room, prior to serving breakfast, Res [initials of | F 0600 | F 600<br>1) Allegations of abuse for residents 6, 7, 19, 5 and 20 identified during the survey were brought to the attention of the Administrator and reported to ISDH via the Gateway portal. Staff and Social Services has continued to follow Residents' 6, 7, 19, 5 and 20 psychosocial well-being with no further concerns reported.<br><br>2) All residents have the potential to be affected by this deficient practice and were interviewed on 5-2-19 using QIS abuse questions to determine if residents have experienced abuse or neglect with no concerns expressed.<br><br>3) All staff were inserviced on identification of abuse on 4-25-19. The Abuse policy was prominently posted in the facility, distributed to all residents, and included in the | 05/29/2019 |

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| | Resident 6] asked Res [initials of Resident 19] can she see his newspaper. [Initials of Resident 19] responded black w----, get the c--- out my face you f------ "B" Resident agitated without provocation...."<br><br>An interview was conducted with COTA 6 on 4/24/19 at 10:11 a.m. She indicated she was in her office and heard Resident 19 cursing at Resident 6, so she left her office and went into the dining room to inquire as to what was going on. COTA 6 indicated Resident 19 was yelling black w---- at Resident 6. COTA 6 indicated she considered Resident 19's comments to Resident 6 verbal abuse.<br><br>An interview was conducted with the Administrator on 4/24/19 at 12:36 p.m. She indicated she considered Resident 19's comments to Resident 6 verbal abuse.<br><br>1b. The 3/14/19 Social Service Alert form for Resident 17, written by the previous Social Services Director who no longer worked at the facility, indicated he was verbally aggressive and socially inappropriate/disruptive. The form read, "Res [Resident 17] lined up to go outside to smoke. Res [Resident 17] was in front of other res door. Res in room [Resident 6] asked res [Resident 17] to move from in front of her door. Res [Resident 17] proceeded to curse at other res, telling her to shut her d--- mouth! Res removed from the situation to resolve it."<br><br>An interview was conducted with the Administrator on 4/24/19 at 2:36 p.m. She indicated she considered Resident 17 cussing at Resident 6 verbal abuse.<br><br>2. The clinical record for Resident 7 was reviewed | | admission packet on 5-2-19. Administrator met with Residents' Council on 5-1-19 regarding identifying abuse and reporting. An updated Abuse Policy was included in the employee new hire packet. Administrator was inserviced on abuse identification and reporting on 4-30-19. The following audits tools will be used to monitor compliance with preventing abuse: QIS resident interview questions; stand up and all staff employee education record; and the Abuse Prevention IRI Audit tool to ensure all components of the abuse policy are followed including identification of abuse.<br><br>4) A continuous sample of residents will be interviewed using QIS abuse questions tool by the Social Worker weekly for three months and bi-monthly thereafter for six months. Administrator or designee will conduct employee stand up tests/education weekly for three months and bi-weekly thereafter for three months; and, all staff education will be conducted bi-monthly for six months. The Abuse IRI audit tool will be used bi-weekly for six months. If any concerns are identified, facility staff will ensure the resident is protected, the allegation is reported, and the allegation is thoroughly investigated by the Administrator. | |

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| | on 4/24/19 at 2:10 p.m. The diagnoses for Resident 7 included, but were not limited to, psychotic disorder and anxiety.<br><br>The 3/15/19 Social Service Alert form for Resident 10 indicated he was verbally aggressive, socially inappropriate/disruptive, and exuded physical aggression. The form read, "While waiting to smoke res [Resident 10] kicking the back of another res [Resident 7] chair. BOM [Business Office Manager] overheard and intervened, ask [sic] res to not kick back of res chair. Res then proceeded to call other res a dumb b---- Res removed from line and away from other res & returned to his rm [room.]"<br><br>An interview was conducted with the BOM on 4/24/19 at 9:38 a.m. The BOM indicated residents were lined up to smoke, and she saw Resident 10 kicking the back of Resident 7's wheel chair. The BOM told Resident 10 to stop, and Resident 10 denied kicking the chair. Resident 10 began cursing, so she assisted him back to his room.<br><br>An interview was conducted with the Administrator on 4/24/19 at 2:33 p.m. She indicated she considered Resident 10's cursing at Resident 7 verbal abuse. 3. The clinical record for Resident 1 was reviewed on 4/23/18 at 9:00 a.m. The diagnosis for Resident 1 included, but was not limited to,diabetic mellitus.<br><br>The 3/16/19 Quarterly MDS (Minimum Data Set) assessment indicated Resident 1 was cognitively intact.<br><br>The clinical record for Resident 19 was reviewed on 4/23/18 at 11:00 a.m. The diagnosis for Resident 19 included, but was not limited to, alcoholic cirrhosis of the liver with ascites. | | The results of these audits will be reviewed by the QAPI committee and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. | |

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The 1/24/19 Quarterly MDS assessment indicated Resident 19 was cognitively intact.

An incident report dated 2/22/19 indicated "... "Brief Description of Incident: Description added -- 2/26/19..On 2/22/19 approximately 4:15 p.m. (Resident 19) was propelling himself down the hall when (Resident 1) came towards (Resident 19) with both arms up and fist closed. (Resident 19) quickly moved his rt (right) hand to shield himself. In doing so he sustained a laceration to his rt hand. No physical contact was made between the two...Immediate Action Taken...2/26/19 Staff intervened immediately residents separated. (Resident 19) hand treated. MD (medical provider), Administrator and families notified...Follow up: Follow up added -- 2/26/19 Both residents were monitored no aggressive behavior..."

A completed investigation for Resident 19 and Resident 1 was provided by the Administrator on 4/24/19 at 3:25 p.m. A typed statement on a piece of paper was provided. It indicated ".. I [name of Administrator] completed an Investigation regarding incident between [Resident 1 and Resident 19]. On 2.22.2019 approximately 4:15pm (sic) [Resident 19] was propelling himself down the hall when [Resident 1] came towards [Resident 19] with both arms up and fist closed. [Resident 19] quickly moved his rt (right) hand to shield himself. In doing so he sustained a laceration to his Rt hand. No physical contact was made between the two. Reportable completed"

An interview was conducted with the Administrator on 4/24/19 at 3:28 p.m. She indicated the incident that occurred on Friday, 2/22/19, between Resident 1 and 19 and was

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| | witnessed by the Maintenance Housekeeping Supervisor. The Maintenance Housekeeping Supervisor reported to her Resident 19 and Resident 1 were propelling down the hall toward each other. During that time, Resident 1 had raised his arms and closed his hands into fists, and at that time Resident 19 held his hands up to cover his face. As Resident 19 was raising his hands to cover his face, he had hit his right hand on something possibly his wheelchair and obtained a skin tear. After, Resident 19's skin tear had been treated. Resident 19 and Resident 1 had not made any physical contact with one another. She indicated after she was told about the incident on Monday she then conducted an investigation. Resident 19 had reported to her he thought Resident 1 was going to hit him. During Resident 1's interview, he had reported he was just going down the hall listening to his radio. He was not going to hit Resident 19.<br><br>An interview was conducted with the Maintenance Housekeeping Supervisor on 4/25/19 at 9:15 a.m. He indicated he had not witnessed an incident between Resident 19 and Resident 1 nor had he reported an incident to the Administrator between Resident 19 and Resident 1 that occurred on Friday, 2/22/19. He had heard about the incident between the two residents. They had gotten into it, and there was physical contact. They had both hit each other.<br><br>An interview was conducted with Resident 1 on 4/25/19 at 11:00 a.m. He indicated a couple of months ago he was in the hallway bending over to pick something up as he was coming up Resident 19 hit him in the jaw. After, he had tried to hit Resident 19 back, but did not make contact. The staff then came up and moved him to his room, but allowed Resident 19 to remain in the hallway. | | | |

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| | Certified Nursing Assistant 10 had witnessed it, but he no longer worked in the facility.<br><br>An interview was conducted with Resident 19 on 4/25/19 at 11:54 a.m. He indicated a couple months back Resident 1 was "talking a bunch of s--- like he always does so I back handed him in the jaw". Resident 1 then tried to hit him back, but was unable. He was unsure if staff witnessed the incident or not. He indicated he did have an injury to his hand, but could not recall if it happened during the incident. 4. The clinical record for Resident 5 was reviewed on 4/22/2019 at 11:10 a.m. The diagnosis for Resident 5 included, but were not limited to bipolar disorder, and personality disorder.<br><br>The clinical record contained a Quarterly MDS (Minimum Data Set) Assessment completed 2/13/2019, indicating Resident 5 was cognitively intact.<br><br>The clinical record for Resident 20 was reviewed on 4/22/2019 at 3:30 p.m. The diagnosis for Resident 20 included, but were not limited to, generalized anxiety disorder and alcohol dependency.<br><br>An Admission MDS (Minimum Data Set) Assessment completed 1/21/2019, indicated Resident 20 was cognitively intact.<br><br>During an interview on 4/22/2019 at 10:29 a.m., Resident 5 indicated that 2 weeks ago another resident had called her a "Fat a--" and she had hit him on the chin. He had then threatened to hit her back. The incident had happened in the activity room.<br><br>The clinical record for Resident 5 contained a | | | |

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| | Nursing Note, dated 4/13/2019, which indicated Resident 5 had told a male resident looked like a b---- and the male resident had called Resident 5 a "Fat a--". She then smacked the male resident on the head. Resident 5 and the male resident were then separated.<br><br>During an interview on 4/23/2019 at 11:00 a.m., the Administrator indicated that Resident 20 and Resident 5 had an incident on 4/13/2019 at 2:15 p.m. She provided the investigation of the incident for review.<br><br>The investigation of the incident indicated on 4/13/2019 Resident 5 had indicated that Resident 20 looked like a "b----" in his glasses and Resident 20 had then called Resident 5 a " Fat a--". Resident 5 then approached Resident 20 and slapped him in the face. Resident 20 then stood and indicated that he would hit her back, but did not make physical contact with her.<br><br>During an interview on 4/26/2019 at 10:20 a.m., Resident 20 indicated a couple of weeks ago he had been slapped by Resident 5. He had threatened to hit her back, but had not done it.<br><br>An interview was conducted with the Administrator on 4/24/19 at 9:32 a.m. She indicated she considered verbal abuse as calling somebody a fat a--, anything that was demeaning, threatening behaviors and verbiage, direct criticism, inappropriate verbiage, and it didn't necessarily have to be profanity.<br><br>On 4/25/2019 at 10:42 a.m., the Region Administrator provided the Abuse Prevention Policy. He indicated it was the current policy in use. The Policy read as follows: "Abuse Preventions, It is the policy of the facility to | | | |

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| | provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with Individual respect and dignity. The following guidelines outline the components of our abuse prevention program...III. Preventing Resident Abuse Policy Statement. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...<br><br>"The Abuse Prevention policy was provided by the Region Administrator on 4/25/19 at 10:42 a.m. It read, "Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability.<br><br>3.1-27(a)(1)<br>3.1-27(b) | | | |
| F 0609 SS=E Bldg. 00 | 483.12(c)(1)(4)<br>Reporting of Alleged Violations<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the | | | |

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| | events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to report and timely report verbal and physical abuse to the Indiana State Department of Health (Resident 6, 7, 5 and 20), and report physical and verbal abuse timely to the Administrator (Resident 19) for 5 of 8 residents reviewed for abuse.<br><br>Findings include:<br><br>1a. The 2/5/19 Social Service Alert form for Resident 19, written by COTA (Certified Occupational Therapy Assistant) 6, indicated he was verbally aggressive, socially inappropriate/disruptive, and used profanities towards Resident 6. It read, "In dinning (sic) room, prior to serving breakfast, Res [initials of Resident 6] asked Res [initials of Resident 19] can she see his newspaper. [Initials of Resident 19] responded black w---- get the c--- out my face you | F 0609 | F 609<br>1) Alleged incidents of abuse regarding residents 6, 7, 5, 19 and 20 which were not reported to the administrator (resident 19) or the appropriate State Authority were identified during the survey and brought to the Administrator's attention, were reported to ISDH via the Gateway portal. Staff and Social Services continues to follow Residents 6, 7, 5, 19 and 20 and their psychosocial well-being with no concerns reported.<br><br>2) All residents have the potential to be affected by this deficient practice and were interviewed on 4-22-19 using QIS abuse questions to determine if residents | 05/29/2019 |

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| | f------ "B" Resident agitated without provocation...."<br><br>An interview was conducted with the Administrator on 4/24/19 at 12:36 p.m. She indicated she considered Resident 19's comments to Resident 6 verbal abuse. The Administrator reviewed her state reportable's in her computer and indicated she did not report this incident of verbal abuse to the Indiana State Department of Health, but should have.<br><br>1b. The 3/14/19 Social Service Alert form for Resident 17, written by the previous Social Services Director who no longer worked at the facility, indicated he was verbally aggressive and socially inappropriate/disruptive. The form read, "Res [Resident 17] lined up to go outside to smoke. Res [Resident 17] was in front of other res door. Res in room [Resident 6] asked res [Resident 17] to move from in front of her door. Res [Resident 17] proceeded to curse at other res, telling her to shut her d--- mouth! Res removed from the situation to resolve it."<br><br>An interview was conducted with the Administrator on 4/24/19 at 2:36 p.m. She indicated she considered Resident 17 cussing at Resident 6 verbal abuse. She indicated she did not report this to the Indiana State Department of Health. She indicated instead of reporting it, she tried to explain to Resident 17 what the situation was.<br><br>2. The 3/15/19 Social Service Alert form for Resident 10 indicated he was verbally aggressive, socially inappropriate/disruptive, and exuded physical aggression. The form read, "While waiting to smoke res [Resident 10] kicking the back of another res [Resident 7] chair. BOM | | have experienced abuse or neglect and/or a failure on the part of management to act. The grievance log for the past six months was reviewed and there were no allegations of abuse or potential abuse that had gone unreported.<br><br>3) All staff were inserviced on identification and reporting abuse on 5-9-19. The Abuse Policy was prominently posted in the facility, distributed to all residents, and included in the admission packet on<br>5-9-19. Administrator met with Residents' Council on 5-1-19 regarding identifying abuse and reporting. An updated Abuse Policy was included in the employee new hire packet. Administrator was inserviced on abuse identification and reporting on 4-30-19. Any future allegations will be reported per facility policy and State/Federal requirements. The following audits tools will be used to monitor compliance with abuse reporting: QIS resident interview questions and stand up and all staff employee education record; and the Abuse Prevention IRI Audit tool to ensure all components of the abuse policy are followed including identification and reporting.<br><br>4) A continuous sample of residents will be interviewed using | |

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| | [Business Office Manager] overheard and intervened, ask [sic] res to not kick back of res chair. Res then proceeded to call other res a dumb b----. Res removed from line and away from other res & returned to his rm [room.]"<br><br>An interview was conducted with the Administrator on 4/24/19 at 2:33 p.m. She indicated she considered Resident 10's cursing at Resident 7 verbal abuse. She indicated she did not report this incident to the Indiana State Department of Health (ISDH), but should have.3. An incident report dated 2/22/19 indicated "... "Brief Description of Incident: Description added -- 2/26/19..On 2/22/19 approximately 4:15 p.m. (Resident 19) was propelling himself down the hall when (Resident 1) came towards (Resident 19) with both arms up and fist closed. (Resident 19) quickly moved his rt (right) hand to shield himself. In doing so he sustained a laceration to his rt hand. No physical contact was made between the two...Immediate Action Taken...2/26/19 Staff intervened immediately residents separated. (Resident 19) hand treated. MD (medical provider), Administrator and families notified...Follow up: Follow up added -- 2/26/19 Both residents were monitored no aggressive behavior..."<br><br>An interview was conducted with the Administrator on 4/24/19 at 3:28 p.m. She indicated the incident that occurred on Friday, 2/22/19, between Resident 1 and 19 was witnessed by the Maintenance Housekeeping Supervisor. The incident had not been reported to her until she had returned to the facility on Monday, 2/26/19. The Administrator indicated after she was notified of the incident she reported it to the State Agency and started the investigation. 4. On 4/23/2019 at 11:00 a.m., the Administrator provided | | QIS abuse questions tool by the social worker weekly for three months and bi-monthly thereafter for six months. Administrator or designee will conduct employee stand up tests/education weekly for three months and bi-weekly thereafter for three months; and, all staff education will be conducted bi-monthly for six months. The abuse IRI audit tool will be used bi-weekly for six months. If any concerns are identified, facility staff will ensure the resident is protected, the allegation is reported, and the allegation is thoroughly investigated by the Administrator. The results of these audits will be reviewed by the QAPI committee and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. | |

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| | the investigation of an allegation of abuse between Resident 5 and Resident 20. The investigation of the abuse indicated on 4/13/2019 at 2:15 p.m., Resident 5 had approached Resident 20 and slapped him in the face. Resident 20 then stood and indicated that he would hit her back, but did not make physical contact with her.<br><br>The investigation contained a copy of the report submitted to the ISDH (Indiana State Department of Health), confirming submission of the incident. The date and time on the report confirmed submission on 4/14/2019.<br><br>During an interview on 4/24/2019 at 9:33 a.m., the Administrator indicated the allegation of abuse occurred on 4/13/2019 at 2:15 p.m... The allegation was reported to the ISDH on 4/14/2019. She had attempted to submit the report on 4/13/2019, however, the facility computer did not save the report. She indicated this was an ongoing problem with the facilities computer and she did not check to assure the report had been submitted. The report should have been sent to the ISDH within 2 hours of the allegation.<br><br>An "Abuse Prevention" policy was provided by the Region Administrator on 4/25/19 at 10:42 a.m. It indicated "...V. Abuse Investigations. Policy Statement. All reports of residents abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Policy Interpretation and Implementation. 1. Allegation of abuse are reported to the State survey agency immediately, as defined within 2 hours via the ISDH (Indiana State Department of Health) portal or telephone, if the portal is inactive. (If by telephone, written notice must be received within 24 hours). Additionally, if the abuse involved serious bodily | | | |

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| | injury. it must be reported to the local law enforcement within 2 hours...VII. REPORTING ABUSE TO: A. FACILITY MANAGEMENT, ISDH, LAW ENFORCEMENT AGENCIES Policy Statement. It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors etc., to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of un unknown source, and theft or misappropriation of resident property to facility management. Policy Interpretation and Implementation... 2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately. 3. The Administrator..must be notified of suspected abuse, allegations of abuse, or incidents of abuse. If such incidents occur or are discovered after hours the Administrator...must be called at home or must be paged and informed of such incident..."<br><br>3.1-28(c) | | | |
| F 0610 SS=E Bldg. 00 | 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or | | | |

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| | her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse, per policy, for 4 of 6 residents reviewed for abuse. (Resident 21, 19, 20, and 5)<br><br>Findings include:<br><br>1. The clinical record for Resident 21 was reviewed on 4/22/19 at 11:27 a.m. The diagnoses for Resident 21 included, but were not limited to, anxiety.<br><br>An interview was conducted with Resident 21 on 4/22/19 at 11:27 a.m. She indicated Resident 6 called her a fat b---- the other day. Resident 21 indicated she told LPN (Licensed Practical Nurse) 8 about the incident and was informed nothing could be done. Resident 21 indicated she was not satisfied with that answer. Resident 21 stated, "I don't think I or any other resident should have to take that from another resident."<br><br>An interview was conducted with the Administrator, regarding Resident 21's allegations against Resident 6, on 4/22/19 at 3:21 p.m. The Administrator indicated she couldn't find any information on Resident 6 cursing at Resident 21, so she was treating it like an allegation of verbal abuse and was investigating it.<br><br>On 4/23/19 at 12:44 p.m., the Administrator provided the investigative documentation into Resident 21's allegations against Resident 6. The Administrator indicated the investigation was | F 0610 | F 610<br>1) The allegations of abuse involving residents 21, 19, 20 and 5 called to the facility's attention during the survey were investigated immediately, including resident and staff interviews. The incidents were reported to ISDH via the Gateway portal. Staff and Social Services has continued to follow Residents' 21, 19, 20 and 5 psychosocial well-being with no concerns reported.<br><br>2) All residents have the potential to be affected by this deficient practice and were interviewed on 5-2-19 using QIS abuse questions to determine if residents have experienced abuse or neglect and whether investigations were initiated and completed.<br><br>3) All staff were inserviced on identification, reporting and investigating abuse on 5-16-19. The Abuse Policy was prominently posted in the facility, distributed to all residents, and included in the admission packet on 5-16-19. Administrator met with Residents' Council on 5-16-19 regarding identifying abuse and reporting. | 05/29/2019 |

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| | complete at this time. The documentation included, in it's entirety, the 4/23/19 follow up report to the Indiana State Department of Health and a 4/22/19, one page written statement from the Administrator.<br><br>The 4/22/19, one page written statement read, "On 4/22/2019, I [name of Administrator] completed an investigation regarding allegations of verbal abuse. This investigation was conducted based on allegations from [name of Resident 21] stating that on 4/21/2019 at approximately 4:30 pm [Name of Resident 6] rolled past [name of Resident 21's] room stopped and called her a f------ b----. I spoke with the charge nurse [name of LPN 8] on shift date of allegation. She stated both residents did yell at each other, however she also stated didn't hear any profanity used from either person. According to [name of LPN 8] [name of Resident 6] yelled shut up [name of Resident 21] I wasn't talking to you. According to [name of LPN 8] [name of Resident 21] yelled don't tell me to shut up. [Name of QMA-Qualified Medication Aide 9] stated she didn't' hear or witness anything." The investigative documentation did not include an interview with the alleged perpetrator (Resident 6), the alleged victim (Resident 21), or any potential witnesses.<br><br>An interview was conducted with the Administrator on 4/23/19 at 11:48 a.m. She indicated she was done with the investigation and closed it out earlier that morning, as LPN 8 indicated she did not witness any profanity being used.<br><br>An interview was conducted with the Administrator on 4/23/19 at 12:27 p.m. She indicated she conducted abuse investigations herself. She took notes with a notepad during | | An updated Abuse Policy was included in the employee new hire packet. Administrator was inserviced on the policy for identifying, reporting and investigating alleged abuse on 4-30-19. The management team will be inserviced on 5-16-19 regarding investigating alleged abuse. Any future allegations will be investigated per facility policy and State/Federal requirements. The following audits tools will be used to monitor compliance with investigating allegations of abuse: QIS resident interview questions; stand up and all staff employee education record; and the Abuse Prevention IRI Audit tool to ensure all components of the abuse policy are followed including investigation.<br><br>4) A continuous sample of residents will be interviewed using QIS abuse questions tool by the social worker weekly for three months and bi-monthly thereafter for six months. Administrator or designee will conduct employee stand up tests/education weekly for three months and bi-weekly thereafter for three months; and, all staff education will be conducted bi-monthly for six months. The abuse IRI audit tool will be used bi-monthly for six months. If any concerns are identified, facility staff will ensure the resident is protected, the | |

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| | interviews, then came back to her computer and typed it up.<br><br>An interview was conducted with Resident 21, in the presence of the Administrator, on 4/24/19 at 9:57 a.m.<br>Resident 21 indicated Resident 12 was present when Resident 6 cursed at her and when she reported it to LPN 8.2. An incident report dated 2/22/19 indicated "... "Brief Description of Incident: Description added -- 2/26/19..On 2/22/19 approximately 4:15 p.m. (Resident 19) was propelling himself down the hall when (Resident 1) came towards (Resident 19) with both arms up and fist closed. (Resident 19) quickly moved his rt (right) hand to shield himself. In doing so he sustained a laceration to his rt hand. No physical contact was made between the two...Immediate Action Taken...2/26/19 Staff intervened immediately residents separated. (Resident 19) hand treated. MD (medical provider), Administrator and families notified...Follow up: Follow up added -- 2/26/19 Both residents were monitored no aggressive behavior..."<br><br>A completed investigation for Resident 19 and Resident 1 was provided by the Administrator on 4/24/19 at 3:25 p.m. A typed statement on a white piece of paper was provided. It indicated ".. I [name of Administrator] completed an Investigation regarding incident between [Resident 1 and Resident 19]. On 2.22.2019 approximately 4:15pm (sic) [Resident 19] was propelling himself down the hall when [Resident 1] came towards [Resident 19] with both arms up and fist closed. [Resident 19] quickly moved his rt (right) hand to shield himself. In doing so he sustained a laceration to his Rt hand. No physical contact was made between the two. Reportable completed" | | allegation is reported, and the allegation is thoroughly investigated by the Administrator. The results of these audits will be reviewed by the QAPI committee and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. | |

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| | An interview was conducted with the Administrator on 4/24/19 at 3:28 p.m. She indicated the incident that occurred on Friday, 2/22/19, between Resident 1 and 19 was witnessed by the Maintenance Housekeeping Supervisor. The typed white piece of paper included all of the documentation for the investigation that was conducted for the incident between Resident 1 and Resident 19 that occurred on Friday, 2/22/19. The Administrator indicated all the statements that were obtained during the investigation were conducted verbally and not documented. 3. During an interview on 4/23/2019 at 11:00 a.m., the ADM (Administrator) indicated that Resident 20 and Resident 5 had an allegation of abuse on 4/13/2019 at 2:15 p.m. She provided the investigation of the incident for review.<br><br>The 1 page investigation of the incident indicated that on 4/13/2019 at 2:15 p.m., Resident 5 had indicated that Resident 20 looked like a "B----" and Resident 20 had then called Resident 5 a "Fat A--". Resident 5 then approached Resident 20 and slapped him in the face. Resident 20 then stood and indicated that he would hit her back, but did not make physical contact with her. It indicated that she had spoken with 2 residents who were present at the time of the incident. It did not indicate that Resident 5 or Resident 20 had been interviewed during the investigation. It did not indicate that staff members on duty at the time of the incident had been interviewed.<br><br>During an interview on 4/23/2019 at 12:30 p.m., the ADM indicated she investigated all allegations of abuse. She had spoken with 2 residents that had witnesses to the allegation and written the summary of findings in the computer. She did not have any further documentation about the | | | |

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| | investigation of the alleged abuse between Resident 20 and Resident 5.<br><br>An "Abuse Prevention" policy was provided by the Region Administrator on 4/25/19 at 10:42 a.m. It indicated "...V. Abuse Investigations. Policy Statement. All reports of residents abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Policy Interpretation and Implementation...2. Should an incident or suspected incident of resident abuse, neglect, or injury of an unknown source be reported to the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 3. The individual conducting the investigation will, at a minimum: a. Review the resident's medical record to determine events leading up to the incident; b. Interview the person(s) reporting the incident; c. Interview any witness to the incident; d. Interview the resident (as medically appropriate); e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. f. Interview the resident's roommate, family members, and visitors;...9. A copy of the completed investigation will be maintained in the facility in a confidential file..."<br><br>3.1-28(d) | | | |
| F 0622 SS=D Bldg. 00 | 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br>Transfer and Discharge Requirements<br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for | | | |

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| | the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) | | | |

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| | of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>Based on interview and record review, the facility | F 0622 | F622 | 05/29/2019 |

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| | failed to ensure transfer and discharge documentation was provided to the receiving provider for 2 of 3 hospitalizations reviewed. (Resident 1 and 26)<br><br>Findings include:<br><br>1. The clinical record for Resident 1 was reviewed on 4/23/18 at 9:00 a.m. The diagnosis for Resident 1 included, but was not limited to,diabetic mellitus.<br><br>A physician order dated 3/26/19 indicated Resident 1 was to be sent to the emergency room to be evaluated for left hip pain.<br><br>A progress note dated 3/26/19 at 4:00 a.m., indicated "Writer went to get resident up for dialysis appointment and was told by resident (Resident 1) that he was not going, he complained of severe pain in left upper leg, leg pain is present at rest and increase (symbol for with) movement and touch, resident stated he fell while LOA (leave of absence) (symbol for with) family previously in the day..."<br><br>A progress note dated 3/26/19 at 5:46 a.m., indicated "...Resident (Resident 1) c/o (complaint) severe pain (symbol for with) movement..."<br><br>A progress note dated 3/26/19 indicated Resident 1 was transferred to hospital by ambulance.<br><br>Resident 1's transfer documentation that was sent with him to the hospital on 3/26/19 to the receiving provider was provided by the Director of Nursing on 4/26/19 at 11:10 a.m. It did not include the following information: Advance Directive, documentation related to Resident 1's on going care, or discharge summary. | | 1) The facility will meet the federal requirements for providing transfer and discharge information to the receiving provider to ensure a safe and effective transition of care for all residents including resident #1 who still resides at the facility.<br><br>2) The facility will meet the federal requirements for providing transfer and discharge information to the receiving provider to ensure a safe and effective transition of care for all residents.<br><br>3) A discharge documents envelope with a checklist of all required transfer and discharge documents will be utilized to ensure information given to the receiving provider is complete. All licensed nursing personnel were Inserviced on 5-17-19 regarding transfer and discharge documentation and procedures. A duplicate copy of the transfer and discharge documents sent will be retained by the Director of Nursing and available for review and audit purposes.<br><br>4) The Director of Nursing or designee will review the copied documentation within 72 hours whenever a resident is transferred or discharged for 3 months and weekly for 3 months and record the findings on the Transfer/Discharge Audit Checklist. The audits will be | |

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| | An interview was conducted with the Director of Nursing on 4/26/19 at 11:12 a.m. She indicated the facility used a transfer Discharge report when residents were transferred to another provider. The transfer discharge report was filled out with the residents status and care needs to provide to the receiving provider. The transfer form was not filled out and sent with Resident 1 to the hospital.<br><br>2. The clinical record for Resident 26 was reviewed on 4/26/18 at 9:00 a.m. The diagnosis for Resident 26 included, but was not limited to,diabetic mellitus.<br><br>A physician order dated 2/16/19 indicated Resident 26 was to be transferred to the hospital for change in condition.<br><br>A progress noted dated 2/16/19 indicated Resident 26 had received a new order to transfer him to the hospital due to change in condition.<br><br>There was no transfer documentation in Resident 26's medical record.<br><br>An interview was conducted with Nurse Consultant (NC) 1, 2 and Director of Nursing (DON) on 4/26/19 at 2:00 p.m. The DON indicated Resident 26 had been sent out to the hospital due to change of condition. NC 2 indicated there was no transfer documentation in his medical chart nor a discharge summary written for the hospitalization.<br><br>3.1-12(A)(6)(B) | | reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0637 SS=D Bldg. 00 | 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg<br>§483.20(b)(2)(ii) Within 14 days after the | | | |

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| | facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>Based on record review and interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment, within 14 days, following a significant change in resident's physical condition related to a decline in activities in daily living (ADL), weight loss and loss/lack of dentures for 1 of 2 residents reviewed for significant change. (Resident 22)<br><br>Findings include:<br><br>a. The record for Resident 22 was reviewed on 4/23/19 at 2:30 p.m.. Diagnosis included, but were not limited to, bipolar disorder, hypertension, right below the knee amputation, left above the elbow amputation, over-active bladder, dysphagia (difficulty swallowing), anxiety and depression.<br><br>The Quarterly Minimum Data Set(MDS) assessment, dated 3/22/19, indicated Resident 22 was cognitively intact for decision making; wore glasses; required extensive two person assistance for bed mobility and transfers; required extensive, one person assistance for dressing; completely dependent when bathing; required a power wheelchair; incontinent of urine frequently; always incontinent of bowel; needed a | F 0637 | F637<br>1) Resident #22's MDS was updated to reflect the resident's current physical condition including ADLs, weight, and dental status.<br><br>2) All resident MDSs were reviewed and updated to ensure any recent significant change in physical status was captured and documented.<br><br>3) The MDS person will review physician orders daily; review 24-hour report; and attend daily IDT morning meeting, and weekly care plan meetings to have every opportunity to gain resident information in addition to reliance upon staff notification; and will update the MDS at first sign of a significant change in resident physical condition. The MDS person, licensed nursing staff and IDT will be inserviced on 5-16-19 regarding signs of significant | 05/29/2019 |

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| | mechanically altered, low sodium diet; and was a risk for pressure ulcers.<br><br>The prior MDS, dated 1/4/19, indicated Resident 22 was cognitively intact for decision making; required supervision for bed mobility, transfers, toilet use and locomotion on and off the unit; required physical help in part for bathing; occasionally incontinent of bladder and was always continent of bowels.<br><br>A Physical Therapy (PT) progress note written on 4/11/19 at 4:49 p.m. indicated, plan for therapy as needed 5 times a week for 30 days.<br><br>An Occupational Therapy (OT) progress note written on 3/7/19 indicated, the resident to be seen 3 times a week for 30 days and treatment to include ADL training, therapeutic exercises and activities, wheelchair management and neuro re-education.<br><br>b. The review of resident's recorded weights on 4/23/19 at 2:30 p.m. indicated, the resident had a weight loss greater than 10% in six months. The resident's monthly weights were: 188.6 lbs (pounds) on 4/15/19 at 10:55 a.m.; 191.2 lbs on 3/25/19 at 11:19 a.m.; resident refused in February and January; 215.3 lbs on 12/13/18 at 9:30 a.m.; 214.6 lbs on 11/16/18 at 4:16 p.m.; and 214 lbs on 10/8/18 at 3:47 p.m..<br><br>c. During an interview with Resident 22, on 4/22/19 at 9:35 a.m., the resident stated she had dentures made while in the facility, but the facility lost them a couple months ago. The resident indicated she had told nursing and the Administrator that her dentures were missing. The resident indicated she had not gone to dentist since dentures went missing. | | change, reporting, and documentation.<br><br>4) The Director of Nursing or designee will review MDS documentation for those residents with significant change to ensure completion weekly for six months and report findings on the MDS Significant Change audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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A care plan written on 3/22/18 indicated the resident has dentures and a care plan revised on 6/21/18 indicated resident refused to wear her dentures.

An interview with Region Administrator, on 4/25/19 at 11:15 a.m. indicated when a report of lost or missing dentures had been made, the facility should have recorded the information in the medical record regarding the lost/missing dentures and the resident should have been referred to dental services within 3 days.

A Dental Log, received from Administrator on 4/24/19, indicated the notes section of the log read, "Auth [Authorization] to [name of physician] sent 6/21/18". The date for last visit section, the follow up section and date of log was left blank.

The Center for Medicaid and Medicare website states, "Significant Change in Status Assessment (SCSA)" is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline. The SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement...Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual 's functioning; Resident 's incontinence pattern changes or there was placement of an indwelling catheter; Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in

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| | 180 days)..."<br><br>3.1-31(d)(1) | | | |
| F 0644<br>SS=D<br>Bldg. 00 | 483.20(e)(1)(2)<br>Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>Based on interview and record review the facility failed to ensure a resident received a psychiatry evaluation, as recommended in the PASARR (preadmission screening and resident review), for 1 of 1 residents reviewed for dementia care (Resident 20).<br><br>Findings include:<br><br>The clinical record for Resident 20 was reviewed on 4/22/2019 at 3:30 p.m. The diagnosis for Resident 20 included, but were not limited to, generalized anxiety disorder and alcohol dependency. | F 0644 | F644<br>1) Resident 20 received a psychiatry evaluation and the care plan was updated to reflect the results of the evaluation.<br><br>2) The PASARR Level IIs of all applicable residents were reviewed to ensure the services indicated were received or are being provided.<br><br>3) All Level II's will be reviewed by Social Services upon admission, | 05/29/2019 |

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| | An Admission MDS (Minimum Data Set) Assessment completed 1/21/2019, indicating Resident 20 was cognitively intact.<br><br>A PASARR, which was completed 1/14/2019, indicating Resident 20 was mentally ill. The services recommended a psychiatric evaluation.<br><br>The clinical record did not contain a consultation note from a psychiatric provider or a care plan addressing the PASARR recommendations.<br><br>During an interview, on 4/26/2019 at 2:25 p.m., the DON (Director of Nursing) indicated Resident 20 had not received a psychiatric consultation.<br><br>On 4/29/2019 at 9:00 a.m., the Region Administrator provided the Ancillary Services Policy. The policy read as follows: "Policy: It is the policy of this facility to provide services including but not limited to: podiatry, optometry, audiology, dental and psych services to meet the residents highest physical, social, and psychosocial well-being at the facility. Procedure: 1. Social Services will maintain an ongoing list of residents who need or desire ancillary services based off of admission consent forms, resident interviews, family interviews, and PASRR recommendations..." | | annually, and updated with any significant change in status assessment so recommendations can be incorporated in the plan of care if needed. The Interdisciplinary team was inserviced on 5-16-19 regarding PASARR Level II requirements.<br><br>4) The IDT will review the PASARR log for new admissions and current residents weekly for three months and monthly for six months with findings documented on the PASARR Log weekly/monthly audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- | | | |

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| | (A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review the facility failed to revise a care plan with individualized needs for 1 of 18 resident reviewed for care plans (Resident 16)<br><br>Findings include:<br><br>The clinical record for Resident 16 was reviewed on 4/22/2019 at 11:36 a.m. The diagnosis for Resident 16 included, but were not limited to, dysfunction of the bladder.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 3/14/2019, indicated Resident 16 was cognitively intact, he had an indwelling catheter in place and had a urinary tract infections. | F 0657 | F657<br>1) Resident 16's tendency to manipulate his catheter and staff education provided were added to the resident's care plan<br><br>2) All resident care plans were reviewed and updated as needed by the Interdisciplinary team to ensure they reflect the resident's current care needs and preferences.<br><br>3) The interdisciplinary team will develop a resident care plan upon admission and update it whenever there is significant change, and at least quarterly on a schedule | 05/29/2019 |

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| | During an interview on 4/22/2019 at 11:36 a.m., Resident 16 indicated that his catheter has gotten clogged and he had gone to the emergency room to have it unclogged.<br><br>A care plan which indicated that Resident 16 had a suprapubic catheter, with a goal for him to remain free from urinary retention or obstruction. The interventions included, but were not limited to, observe for signs and symptom of urinary tract infections and urinary retention, observe output each shift and provide assistance with skin care after episodes of urinary dribbling from suprapubic catheter as needed.<br><br>A Physician's Order dated 4/4/2019 indicated Resident 16 was to be sent to the emergency room due to his catheter being clogged.<br><br>During an interview on 4/29/2019 at 11:56 a.m., the ADON (Assisted Director of Nursing) indicated Resident 16 often manipulates his catheter. He has put the catheter drainage bag over his shoulder at times or placed it in his waist band. Staff had offered re-education to him, and informed him that doing these things could cause him to have urinary tract infections or clog his catheter, however, he would continue to do those things after re-education.<br><br>During an interview on 4/29/2019 at 12:04 p.m., the DON (Director of Nursing) indicated that the care plan should have updated to include this information.<br><br>On 4/26/2019 at 3:40 p.m., Nurse Consultant 2 provided the Care Plans- Comprehensive Policy, revised August 2006, which reads as follows: "Policy Statement- An individualized Comprehensive Care Plan that includes | | maintained by the MDS coordinator. All nursing staff and members of the IDT were inserviced on 5-16-19 regarding person centered care plans and timely updates.<br><br>4) The Director of Nursing or designee will oversee weekly care plan meetings with the interdisciplinary team to ensure care plans are reviewed on a time frame which reflects regular quarterly reviews and significant resident changes to ensure they are a current reflection of the resident's care needs. Documentation of the meetings will be reflected in brief care plan minutes which will be retained and reviewed by the administrator weekly for six months. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation...3. Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem areas; b. incorporate risk factors associated with identified problems....5. Care plans are revised as changes in the resident's condition dictate..."<br><br>3.1-35(d) (2) (B) | | | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on interview and record review, the facility failed to provide showers twice weekly, as care planned and to provide necessary services to maintain personal hygiene and oral care related to dry, flaky skin on resident's legs and peeling lips for 2 of 2 residents reviewed for ADLs (activities of daily living.) (Resident 10 and 13)<br><br>Findings include:<br><br>1. The clinical record for Resident 10 was reviewed on 4/22/19 at 2:00 p.m. The diagnoses for Resident 10 included, but were not limited to, dementia, hemiplegia, and history of right shoulder replacement.<br><br>The 3/8/19 Quarterly MDS (Minimum Data Set) assessment indicated Resident 10 required physical help in part of bathing, with one person's physical assistance. | F 0677 | F677<br>1) Resident 10 received a shower and his bathing preference was confirmed and care plan updated. Resident 13's skin was assessed, and a physician's order received to apply lotion to skin.<br><br>2) Interviewable residents were asked if they received assistance with ADLS; and weekly skin assessments and shower sheets were reviewed for the past 30 days. All resident ADL care plans were reviewed and updated.<br><br>3) An inservice for all nursing staff on providing ADL care for dependent residents was held on 5-9-19. Charge nurses will review | 05/29/2019 |

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| | An interview was conducted with Resident 10 on 4/22/19 at 2:38 p.m. He indicated his shower days were scheduled for Mondays and Thursdays, but he was lucky to get one shower a week. He indicated he needed assistance washing his hair and his back.<br><br>The ADL care plan, revised 6/12/18, for Resident 10 indicated he had a self care performance deficit and required assistance with bathing/showering twice weekly and as necessary.<br><br>The April, 2019 shower sheets and April, 2019 bathing logs were provided by the DON (Director of Nursing) on 4/25/19 at 2:55 p.m. and 4/26/19 at 3:15, respectively. At this time, the DON indicated Resident 10 was missing verification of 2 showers. The shower sheets and bathing logs indicated no verification of bathing or refusals of bathing from 4/8/19 to 4/15/19 and 4/18/19 to 4/25/19.<br><br>An interview was conducted with Nurse Consultant 1 on 4/26/19 at 12:16 p.m. She indicated Resident 10 should have received an additional shower between 4/8/19 and 4/15/19 and an additional shower between 4/18/19 to 4/25/19.<br><br>The Showering a Resident While Using a Shower Bed policy was provided by NC 1 on 4/26/19 at 2:22 p.m. It read, "Residents will receive a shower at least two times a week unless condition warrants otherwise or Resident refuses. A shower will clean, refresh, and soothe the Resident also it will stimulate circulation."2. An observation made on 4/22/19 at 11:16 a.m., Resident 13 had dry skin on bilateral legs and chapped lips.<br><br>On 4/26/19 at 12:10 p.m., during observation of Resident 13, his lips were peeling and appeared | | skin assessments and shower sheets daily on their shift for any irregularities or need for medical intervention. Oral care will be observed during med pass each shift.<br><br>4) An ADL care audit assigned to charge nurses by the Director of Nursing will be used to monitor completion of showers, skin care and oral care daily, rotating shifts. The Director of Nursing will collect and review the audits daily for two months and weekly for four months. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | dry. Resident 13's legs were scaly and dry. In an interview at this time, the resident indicated no one put lotion and lip balm on him and he had dry skin and dry lips.<br><br>The record review for Resident 13 was completed on 4/26/19 at 10:15 a.m.. Diagnosis included, but not limited to, hypertension, dementia, dysphagia (difficulty swallowing), cerebralvascular accident (CVA), hemiplegia (inability to move one half of body) and pseudobubular affect (inappropriate, involuntary expression due to a nervous system disorder).<br><br>The Quarterly Minimum Data Set(MDS) assessment, dated 3/19/19, indicated Resident 13 was cognitively deficient for decision making; required extensive assistance of two people for bathing; and had range of motion limitations related to upper and lower impairments.<br><br>The Care Plan, dated 3/15/19 indicated to observe and do skin assessment weekly related to the potential for skin tears. Resident had fragile skin, anemia, muscle spasms, abnormal posture. Resident was total care for ADL's. Other interventions included: update the doctor about new skin issues daily and as needed; Provide skin treatments as ordered, monitor and record response; and Observe skin for abnormalities, swelling, redness, drainage, etc.<br><br>The Skin Check Sheet dated for February on the 2 p.m. to 10 p.m. shift indicated on 2/7, 2/14, 2/21 and 2/28 that his skin was intact; January 1/3, 1/10, 1/17, 1/24 and 1/31 that his skin was intact; and the quarterly nursing assessment, dated 3/10/19, indicated dry skin and no skin abnormalities. | | | |

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| | During an interview with Resident 13 on 4/26/19 at 01:33 p.m., he indicated he had asked for lotion and lip balm multiple times from the aides and nurses. He also indicated he used to purchase his own lotion and balm but it kept getting stolen.<br><br>On 4/26/19 at 01:44 p.m., during an interview with DON, she indicated the weekly skin assessments needed to note the dryness of resident's skin and lips. The application of lotion/lip balm should be listed on TAR (treatment administration record), but was not listed. The resident had lotion in his room that the facility had provided and does not require a prescription. Lotion application was part of the bathing routine the aides perform. Based on the level of dry skin resident had despite having lotion in room, the observation of dry skin/dry lips should have been noted on skin assessment sheets and the physician should have been notified as therapeutic lotion could have been prescribed for resident.<br><br>3.1-38(a)(3)<br>3.1-38(a)(3)(C) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on interview and record review, the facility failed to administer insulin, as ordered, to clarify a physician order to obtain a resident's blood | F 0684 | F684<br>1) Resident 10's sliding scale Humalog order was clarified by the | 05/29/2019 |

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| | pressure prior to administration of blood pressure medication and notifying the provider of a weight gain as ordered for 2 of 6 residents reviewed for quality of care. (Resident 2 and 10)<br><br>Findings include:<br><br>1. The clinical record for Resident 10 was reviewed on 4/22/19 at 2:00 p.m. The diagnoses for Resident 10 included, but were not limited to, diabetes mellitus.<br><br>An interview was conducted with Resident 10 on 4/22/19 at 2:34 p.m. He indicated some nurses gave him 2 shots of insulin at night, and some nurses gave him one shot of insulin at night. He stated, "I'm not sure how much insulin I'm supposed to get."<br><br>The diabetes care plan for Resident 10 indicated an intervention was to give him medication as ordered by the doctor.<br><br>The April, 2019 physician's orders for Resident 10 indicated to check his blood sugar 4 times daily at meals and before bedtime, effective 1/20/19. The orders indicated to administer Humalog 100 Unit/ML, per sliding scale, at meals and at bedtime as follows:<br><br>151 - 200 = 4 units<br>201 - 250 = 6 units<br>251 - 300 = 8 units<br>301 - 350 = 10 units<br><br>An interview was conducted with the DON (Director of Nursing) on 4/29/19 at 9:55 a.m. She indicated the physcian's orders in Resident 10's paper clinical record indicated the sliding scale Humalog was to be given 4 times daily, but | | physician and the Fingerstick and Insulin Administration form reviewed to ensure it matched; and resident is receiving Humulog as ordered. Resident 2's blood pressure medicine and "check BP" order was clarified, and the Medication Administration Record reviewed to ensure it matched; and resident is receiving blood pressure medication as ordered. Resident 2's order for daily weights and "notify physician" order was clarified, and the Medical Administration Record reviewed to ensure it matched; and resident is receiving daily weights and physician notified as ordered.<br><br>2) Physician's orders for medication and/or physician notification, and corresponding documentation records, were reviewed and clarified for: residents with sliding scale insulin; blood pressure medicines; and residents with daily weights.<br><br>3) Licensed nursing staff were inserviced on documenting physician's orders for medication and/or physician notification, and corresponding documentation records, for residents with sliding scale insulin; blood pressure medicines; and residents with daily weights on 5-16-19.<br><br>4) The Director of Nursing or | |

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| | Resident 10's electronic health record indicated it was to be given 3 times daily. The DON reviewed Resident 10's April, 2019 Fingerstick & Insulin Administration Form and indicated nursing was administering sliding scale Humalog at 9:00 p.m., on some days, and other days they were not, even when the reading indicated as such.<br><br>On 4/29/19 at 1:05 p.m., the DON provided a clarification from Resident 10's physician indicating his sliding scale Humalog was to be administered a total of 4 times a day.<br><br>The April, 2019 Fingerstick & Insulin Administration Form and April, 2019 medication administration record indicated Resident 10's blood sugar was not checked at bedtime on 4/23/19. They indicated the following blood sugar readings at 9:00 p.m. (his 4th daily blood sugar reading), at the following dates, with no sliding scale Humalog given as ordered:<br>4/1/19 - 214<br>4/9/19 - 237<br>4/26/19 - 195<br>An interview was conducted with the DON on 4/29/19 at 1:05 p.m., when she acknowledged Resident 10 should have received sliding scale Humalog on the above dates at 9:00 p.m.<br>2a. The clinical record for Resident 2 was reviewed on 4/23/18 at 10:00 a.m. The diagnoses for Resident 2 included, but were not limited to, acute systolic and diastolic congested heart failure and hypertension.<br><br>A physician order dated 2/1/18 indicated Resident 2 was to receive 10 milligrams of hydralazine three times a day for a diagnosis of hypertension.<br><br>A physician order dated 2/1/18 indicated Resident 2 was to receive 50 milligrams of metoprolol twice | | designee will monitor the medication administration records daily for two months and weekly for four months; and document findings on the MAR/TAR documentation audit form, to ensure administration and documentation is complete. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | a day for a diagnosis of hypertension.<br><br>A physician order for Resident 2 dated 3/1/19 indicated "...Hold blood pressure medication for SBP (systolic blood pressure) (symbol for less than) 100, Notify md (medical doctor) of SBP (symbol for greater than) 150..."<br><br>The April 2019 MAR for Resident 2 indicated the metoprolol was administered at 8:00 a.m., and 8:00 p.m., daily, and the hydralazine was administered at 8:00 a.m., 1:00 p.m., and 5:00 p.m., daily. There were no documented blood pressures that staff had obtained on the April MAR.<br><br>The electronic medical record for Resident 2 indicated on 4/1/19 at 3:00 p.m., a blood pressure reading for Resident 2 was 142/72.<br><br>An interview was conducted with the Assisted Director of Nursing (ADON) on 4/24/19 at 11:32 a.m. She indicated the blood pressure monitoring was missed missed on the April MAR. She also had thought the staff was to obtain the blood pressure prior to administering the metoporolol not the hydralazine. She would need to call the doctor for clarification if that order included the hydralazine medication as well.<br><br>2b. A physician order dated 3/17/18 indicated Resident 2's weight should be taken daily. The staff was to notify the provider if Resident 2 had a 2 pound weight gain overnight or 5 pounds in one week.<br><br>A physician order dated 5/30/18 indicated Resident 2 was on a fluid restriction of 2 liters per day.<br><br>The March 2019 Medication Administration | | | |

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| | Record (MAR) for Resident 2 indicated the following weights:<br><br>3/4/19 - 246.4 pounds,<br>3/5/19 - 249.2 pounds - 2.8 pound gain,<br>3/27/19 - 249.8 pounds,<br>3/28/19 - 252.2 pounds - 2.4 pound gain,<br><br>There was no documentation in medical record the provider was notified of weight gain.<br><br>The April MAR for Resident 2 indicated the following weights:<br><br>4/1/19 - 250.6 pounds,<br>4/2/19 - 256.8 pounds - 6.2 pound gain,<br>4/16/19 - 252.4 pounds,<br>4/17/19 - 254.6 pounds - 2.2 pound gain,<br><br>There was no documentation in medical record the provider was notified of weight gain.<br><br>An interview was conducted with the Assistant Director of Nursing (ADON) on 4/24/19 at 11:32 a.m. She indicated the staff should be notifying the provider about the weight gain as ordered. If staff notified the provider it would be documented on the back of the MAR or progress notes. She could not located any documentation the provider was notified of weight gains in March or April.<br><br>3.1-37(a) | | | |
| F 0685<br>SS=D<br>Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- | | | |

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| | §483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>Based on interview and record review the facility failed to assure a resident received prescription glasses timely, and to ensure the resident received proper treatment to maintain vision related to making appointments and arrangement for transportation for repair of eyeglasses for 2 of 2 residents reviewed for vision (Resident 20 and 22).<br><br>Findings include:<br><br>1. The clinical record for Resident 20 was reviewed on 4/22/2019 at 3:30 p.m. The diagnosis for Resident 20 included, but were not limited to, generalized anxiety disorder and alcohol dependency.<br><br>An Admission MDS (Minimum Data Set) Assessment completed 1/21/2019, indicated Resident 20 was cognitively intact.<br><br>During an interview on 4/22/2019 at 3:23 p.m., Resident 20 indicated he had seen an eye doctor about a month ago. He had been fitted for new glasses, but he had not received them yet.<br><br>A social service progress note dated 3/11/2019, indicated Resident 20 had been seen by the eye doctor and his new glasses should have been received a couple weeks after the visit.<br><br>During an interview on 4/26/2019 at 11:15 a.m., the | F 0685 | F685<br>1) Resident 20's glasses have been received. Resident 22 had an eye appointment with outside practitioner during survey.<br><br>2) There are no other residents pending eye exams or glasses currently.<br><br>3) Social Services will post the upcoming Optometrist visit dates well in advance on the facility information bulletin board. As the date of Optometrist visit draws near, Social Services will circulate a referral list to be completed by staff and or resident so resident can be seen on the day of visit. If a resident prefers services by an outside practitioner, Social Services will arrange the appointment and transportation for the resident. The name and contact information of the Optometrist is included in the resident admission packet and posted in the facility. Social Services shall keep an Ancillary Services Provider Log for residents scheduled to be seen and when; | 05/29/2019 |

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| | DON (Director of Nursing) indicated that she was unsure why the glasses had not been received and that social services would normally follow up with the eye doctor.<br><br>During an interview on 4/26/2019 at 11:30 a.m., CNA (Certified Nursing Assistant) 4 indicated she was assisting with social services and would follow up on why Resident 20 had not received his eye glasses.<br><br>During an interview on 4/26/2019 at 2:44 p.m., Nurse Consultant 1 indicated Resident 20 should have received his glasses. 2. On 4/22/19 at 11:15 a.m., an observation was made of Resident 22 wearing a pair of glasses that had a missing lens.<br><br>The record review for Resident 22 was completed on 4/23/19 at 2:30 p.m.. Diagnosis include, but were not limited to, bipolar disorder, right below the knee amputation, left above elbow amputation, dysphagia (difficulty swallowing) and anxiety.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/22/19, indicated the resident was cognitively intact and wore glasses.<br><br>During an interview conducted on 4/22/19 at 2:32 p.m. with Resident 22 , she indicated she had an appointment to get her glasses repaired weeks ago but the transportation van never arrived at the facility to pick her up for her appointment. She stated that now she had to wait four months to see the doctor.<br><br>During an interview on 4/23/19 at 12:07 p.m., CNA 4, indicated she would be the new Social Service (SS) person, and residents needs for ancillary services was being handled through close coordination between the nurse and the | | services provided during the visit; and any pending work that needs to be done and/or follow up, e.g. eyeglasses on order. Social Services was inserviced on provision of optometric services and maintaining the Provider Log on 5-1-19. All staff were inserviced on the provision of optometric services and the referral process on 5-2-19.<br><br>4) Administrator will monitor the provision of optometric services by reviewing the Log weekly for 3 months and monthly for six months. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | Administrator.<br><br>During an interview with the Administrator on 4/24/19 at 2:09 p.m., the Administrator indicated Resident 22 made her own appointments for eye glasses and did not know why the transportation van did not pick her up that day. The social services department would take care of this but the new person has not taken the required course. She stated the facility used (name of company) for vision, hearing and dental. The administrator then called (name of company)and received the last treatment notes for Resident 22 which stated, "resident seen on 5/7/18 for complaints of blurred vision, check cataracts, dry eyes; examination indicated plan is: 1. eyeglasses, current prescription is OK; 2. Monitor for decreased vision; 3. monitor, lid hygiene, 4. monitor with follow up and return in 6 months.<br>The administrator could not locate notes related to a new or follow up appointment being made for resident nor an attempt to make further travel arrangements.<br><br>On 4/29/2019 at 9:00 a.m., the Region Administrator provided the Ancillary Services Policy. The policy read as follows: "Policy: It is the policy of this facility to provide services including but not limited to: podiatry, optometry, audiology, dental and psych services to meet the residents highest physical, social, and psychosocial well-being at the facility. Procedure: 1. Social Services will maintain an ongoing list of residents who need or desire ancillary services based off of admission consent forms, resident interviews ..."<br><br>3.1-39(a)(1)<br>3.1-39(a)(2) | | | |

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| F 0697<br>SS=D<br>Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on interview and record review, the facility failed to appropriately assess a resident's potential for pain, consistent with his condition for 1 of 1 resident reviewed for pain management and to provide nonpharmacological interventions to a resident with pain for 1 of 6 residents reviewed for unnecessary medications. (Resident 7 and 10)<br><br>Findings include:<br><br>1. The clinical record for Resident 10 was reviewed on 4/22/19 at 2:00 p.m. The diagnoses for Resident 10 included, but were not limited to: chronic pain syndrome, osteoarthritis, depression, and a history of right shoulder replacement.<br><br>The 3/8/19 Quarterly MDS (Minimum Data Set) assessment indicated he was cognitively intact.<br><br>An interview was conducted with Resident 10 on 4/22/19 at 2:41 p.m. He indicated he had a right shoulder replacement, that his right shoulder hurt all the time, and on a scale of 1 to 10, it stayed a 7.<br><br>The pain medication care plan, revised 6/11/18, indicated an intervention was to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.<br><br>The April, 2019 physician's orders indicated | F 0697 | F697<br>1) Residents' 7 and 10 pain assessments were updated and documented including the MDS and resident care plan.<br><br>2) All residents current pain assessments were reviewed and updated as needed on the MDS and resident care plan.<br><br>3) Licensed nursing staff were inserviced on pain management, including nonpharmacological interventions; and the documentation of pain medicine administration and nonpharmacological interventions on the Medical Record Administration Record and Pain Flowsheet on 5-2-19.<br><br>4) The Director of Nursing or designee will monitor by reviewing the MAR and Pain Flowsheets daily for 2 months and weekly for four months. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If | 05/29/2019 |

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| | regularly scheduled acetaminophen (650 mg) once daily at noon for generalized pain. The orders indicated acetaminophen (650 mg) every 4 hours as needed (PRN) for pain and tramadol (100 mg) every 6 hours as needed for pain.<br><br>The April, 2019 MAR (medication administration record) indicated he received the regularly scheduled 650 mg of acetaminophen daily, but had not received any administrations of the PRN acetaminophen or tramadol.<br><br>An interview was conducted with Resident 10 on 4/29/19 at 10:40 a.m. He indicated he'd informed nursing prior that his pain was at least a 7 on a daily basis, and that it extended down his forearm. He indicated he did not tell them everyday, nor did staff ask him on a daily basis about his pain. He indicated he was unaware he had PRN pain medication available to him, and thought he was getting tramadol everyday, regularly scheduled. He stated, "I thought I was getting the tramadol everyday here. Well no wonder I'm still in pain."<br><br>An interview was conducted with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) on 4/29/19 at 10:58 a.m. The DON indicated Resident 10 should ask nursing for his PRN pain medication. She stated, "I think he just forgot he could ask for it. He forgets our names." The ADON indicated nursing should be assessing Resident 10's pain every time they gave him his regularly scheduled tylenol. The ADON stated, "We should ask him about his pain, is he having any, location, scale and it should be documented if he says yes or no." The ADON reviewed Resident 10's March and April, 2019 nurses notes and MARs, and stated, "It's not charted in notes or in the MARs."<br>2. The clinical record for Resident 7 was reviewed | | threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | on 4/24/18 at 1:00 p.m. The diagnosis for Resident 7 included, but was not limited to, cerebral infarction (stroke).<br><br>A care plan dated 5/5/18 indicated "..Resident (Resident 7) receives scheduled pain related to: polyneuropathy, muscle spasms and restless leg syndrome..Receives prn (as needed) pains (sic) medications...Interventions: Adm (administer) medications as ordered observe for effectiveness..Date initiated 5/5/18. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition...Date initiated 5/5/18...Observe/record/report to nurse loss of appetite, refusal to eat and weight loss,..Date initiated 5/5/18...Observe/record/report to Nurse resident complaints of pain or requests for pain treatment..Date initiated 5/5/18..Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx (signs and symptoms) or c/o (complaints of) pain or discomfort...Date initiated 5/5/18...When resident allows attempt non pharm (pharmacological) interventions such as: repositioning, gentle stretching, offer low lighted area prior to prn medication administration..Date initiated 4/25/19..."<br><br>A physician order dated 2/7/19 indicated Resident 7 was to receive 10-325 milligrams of hydrocodone every 6 hours for pain as needed.<br><br>The March 2019 Medication Administration Record (MAR) indicated Resident 7 had received the as needed hydrocodone medication daily for pain. | | | |

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| | The April 2019 MAR indicated Resident 7 had received the as needed hydrocodone medication daily for pain.<br><br>There were no nonpharmacological interventions documented on the March or April MAR nor in Resident 7's medical record prior to the administration of the as needed pain medication.<br><br>An interview was conducted with Nurse Consultant (NC) 2 on 4/26/19 at 2:37 p.m. She indicated if there were nonpharmacological interventions that were provided to Resident 7 the staff would write them on the back of the MARS or a nursing progress note would be documented. NC 2 could not locate any nonpharmacological interventions that were attempted on the March or April MARs nor could she locate any nursing notes related to nonpharmacological interventions.<br><br>A Pain Assessment and Management policy was provided by NC 1 on 4/26/19 at 3:19 p.m. It indicated "..Purpose. The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain...Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain....Ask the resident if he/she is experiencing pain....The physician and staff will establish a treatment regimen based on consideration of the following: a. The resident's medical condition; b. Current medication regimen..Implementing Pain Management Strategies: 1. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: 1. Environmental - adjusting | | | |

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| | the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; b. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. Exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. Cognitive or Behavioral - relaxation, music, diversions, activities, etc..."<br><br>3.1-37(a) | | | |
| F 0732<br>SS=C<br>Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors. | | | |

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| | §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>Based on observation, interview and record review, the facility failed to ensure current staffing was posted daily. This had the potential to effect 27 of 27 residents that reside in the facility.<br><br>Findings include:<br><br>Observations were made of the wall by the Administrator's office on 4/29/19 at 8:30 a.m. and 11:25 a.m. The staffing form that was posted was dated 4/24/19.<br><br>An interview was conducted with the Certified Nursing Assistant 4 on 4/29/19 at 11:31 a.m. She indicated the staffing posted was suppose to be changed daily. She was unaware the posting had not been changed since 4/24/19. She would place a current staff posting form up on the wall.<br><br>A "Posting Direct Care Daily Staffing Numbers" policy was provided by the Nurse Consultant 2 on 4/29/19 at 11:51 a.m. It indicated "...Policy Statement. Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation. 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RN's | F 0732 | F732<br>1) 2) The posting of Nurse Staffing Information effects all residents. The nurse staffing information is posted daily in the reception area at the front entrance and is accessible to residents, staff and visitors.<br><br>3) The daily posting includes the current date; The total number and actual hours worked by RNs, LPNs, QMAs and CNAs; and the resident census. The Nurse Staffing Information is posted Monday through Friday by the Business Office Manager and by the Manager on Duty Saturday and Sunday. The department heads were inserviced on 4-30-19 regarding Nurse Staffing Information posting requirements.<br><br>4) The administrator or designee will check the posting daily for one month and weekly on alternating days for five months and document findings on the Nurse | 05/29/2019 |

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| | (Registered Nurse), LPNs (License Practical Nurse), and LVNs (Licensed Vocational Nurse), and the number of unlicensed nursing personnel (CNAs, Certified Nursing Assistant) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format..." | | Staffing Information audit. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0740 SS=D Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>Based on observation, interview and record review the facility failed to address behavioral changes and update behavior management plans for 1 of 6 resident's reviewed for abuse. (Resident 5).<br><br>Findings include:<br><br>The clinical record for Resident 5 was reviewed on 4/22/2019 at 11:10 a.m. The diagnosis for Resident 5 included, but were not limited to bipolar disorder, and personality disorder.<br><br>A Quarterly MDS (Minimum Data Set) Assessment completed 2/13/2019, indicating Resident 5 was cognitively intact. | F 0740 | F740<br>1) Resident 5's behavior history was reviewed by the IDT and the care plan updated to include interventions to be implemented for exhibited behaviors. Resident 5's behavior plan was updated in the Behavior Log Book.<br><br>2) The IDT reviewed all residents with history of behavior and their care plans were updated including interventions to be implemented for exhibited behaviors. The behavior plans were updated in the Behavior Log Book. | 05/29/2019 |

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| | A Nursing Note, dated 4/13/19, indicating that Resident 5 had struck a male resident in the head.<br><br>The clinical record did not contain a care plan addressing the behavior of physically striking another resident.<br><br>During an interview on 4/24/2019 at 2:21 p.m., the DON (Director of Nursing) indicated she had not been aware of Resident 5's action until 4/24/2019. Social Services would normally handle new behavior care plans.<br><br>During an interview on 4/25/2019 at 2:45 p.m., QMA (Qualified Medication Aide) 5 indicated that when resident's exhibit behaviors it would have been documented in the behavior log. The behavior log contained care plans with interventions to be implemented for exhibited behaviors.<br><br>On 4/26/2019 at 2:32 p.m., NC (Nurse Consultant) 1 provided Resident 5's Behavior Management Record. The record listed 6 behaviors which Resident 5 was known to exhibit. The record did not list physical aggression or striking others as a known exhibited behavior.<br><br>During an interview on 2/26/2019 at 2:45 p.m., NC 1 indicated the Behavior Management Record, which was provided, for Resident 5 was from March 2019. There was no Behavior Management Record present for April 2019.<br><br>During an interview on 04/29/2019 at 11:38 a.m., the Region Administrator indicated the Resident's behaviors were to be documented by any staff member in the behavior log. New behaviors were documented on a social service referral form. Behaviors were to be reviewed daily in morning | | 3) Behavior incidents are reported by staff to Social Services by completing a Behavior Referral Form or noting the behavior directly in the Behavior Log Book. New Behavior Referrals and the Behavior Log Book are brought to morning meeting and reviewed by the Interdisciplinary Team. The resident's behavior care plan and the Behavior Log Book are updated, and any new interventions added. All staff will be inserviced on 5-16-19 regarding resident behaviors; behavior intervention; reporting behaviors and documentation.<br><br>4) The administrator will monitor by ensuring the Behavior Referrals and Behavior Log Book are reviewed by the IDT at morning meeting and behavior care plans and interventions are updated. An audit form will be used to document the daily as needed reviews for six months. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | meeting. The new behavior would have been discussed in the morning meeting by the IDT (Interdisciplinary Team) and care plan would have been created or updated at that time. A Quality Assurance form was to be filled out in morning meeting. Social Service would have made a progress note and added new behavior to the behavior log.<br><br>During an interview on 4/29/2019 at 11:40 a.m., NC 1 indicated the behavior process had not been carried out completely because there had not been a Social Worker. The IDT team was still discussing behaviors in morning meetings, however progress notes were not being made.<br><br>On 4/24/2019 at 3:17 p.m., NC 1 provided the Behavior Management Policy, revised 12/2015, which read as follows: "Policy, Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents. Sometimes, a resident becomes dangerous to himself or abusive to others and may keep others from enjoying a quiet and peaceful place. The staff should assess the behaviors and document in a quantitate manner, to assist in determining whether the behaviors can be addressed in the facility or whether outside assistance may be needed...Protocol, Each resident with identified behaviors...will be monitored for episodes of behaviors [See Behavior Management Record]...General Plan, A behavior management form for each resident with identified behaviors..."<br><br>3.1-43(a)(1) | | | |
| F 0756 SS=D | 483.45(c)(1)(2)(4)(5)<br>Drug Regimen Review, Report Irregular, Act | | | |

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| Bldg. 00 | On<br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the | | | |

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| | pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>Based on interview and record review, the facility failed to timely act upon pharmacy reports for 1 of 6 residents reviewed for pharmacy reviews. (Resident 21)<br><br>Findings include:<br><br>The clinical record for Resident 21 was reviewed on 4/22/19 at 11:27 a.m. The diagnoses for Resident 21 included, but were not limited to, anxiety.<br><br>The physician's orders for Resident 21 indicated Alprazolam 1 mg tablet to be administered at bedtime as needed (PRN) for anxiety, effective 11/9/18.<br><br>The 2/7/19 pharmacy report for Resident 21 read, "[Name of Resident 21] has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Alprazolam 1 mg. Recommendation: Please discontinue PRN Alprazolam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Rationale for Recommendation: CMS [Centers for Medicare and Medicaid Services] requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order." There was no physician response for this recommendation until 4/23/19, that the PRN Alprazolam order was discontinued on 4/12/19 | F 0756 | F756<br>1) Resident 21's medication record was reviewed at the time of the survey and cross-referenced with any applicable pharmacist recommendations made during the previous ninety days. Any that applied were called to the physician's attention and orders received.<br><br>2) All pharmacy recommendations for the last ninety days were reviewed for follow-up, including medication changes and labs. Applicable recommendations were brought to the attending physician's attention for action as appropriate.<br><br>3) Pharmacy recommendations will be reviewed and delivered to MD in a timely manner for consultation and possible order changes. Recommendations will be submitted to MD via fax upon receipt and a copy will be placed in MD follow-up book for review at next visit. All pharmacy consults will be kept on record with fax verification of delivery to MD. The Director of Nursing and licensed staff were inserviced on 5-9-19 regarding pharmacist recommendations, communication with the attending, and implementation. | 05/29/2019 |

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| | and new orders were written.<br><br>The 3/26/19 pharmacy recommendation for Resident 21 read, "[Name of Resident 21] currently has the following pertinent PRN medication order: Alprazolam 1 mg...State and Federal Guidelines have been updated and include 14 day limits on PRN psychotropics...Please consider the following at this time: DC [Discontinue] PRN Alprazolam OR Add Stop Date to Alprazolam & Clinical Rationale for Therapy >[greater] 14 Days." There was no physician response for this recommendation until 4/23/19, that the PRN Alprazolam order was discontinued and changed to routine on 4/12/19.<br><br>An interview was conducted with Nurse Consultant 1 on 4/26/19 at 3:25 p.m. She indicated she just gave the January through March, 2019 pharmacy recommendations to the physician that week, and was unsure why they were not being completed timely.<br><br>3.1-25(i) | | 4) The Director of Nursing or designee will use an audit tool to monitor compliance with each pharmacy consult to ensure the process is completed monthly for six months and ongoing. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance. | |
| F 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or | | | |

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| | §483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on interview and record review, the facility gave insulin in excessive dosages for 2 of 6 residents reviewed for unnecessary medications. (Resident 18 and 21)<br><br>Findings include:<br><br>The clinical record for Resident 21 was reviewed on 4/22/19 at 11:27 a.m. The diagnoses for Resident 21 included, but were not limited to, anxiety.<br><br>The April, 2019 physician's orders for Resident 21 indicated for blood sugar readings to be done 4 times daily. They indicated for Humalog (insulin) 100 Unit/ML to be administered per sliding, three times daily (6:00 a.m., 12:00 p.m., and 5:00 p.m.), for blood sugar readings as follows:<br><br>151-200 = 2 Units<br>201-250 = 4 Units<br>251-300 = 6 Units<br>301-350 = 8 Units<br><br>The April, 2019 Fingerstick & Insulin Administration Form for Resident 21 indicated the sliding scale Humalog was administered at 9:00 p.m., the time of the fourth daily blood sugar reading, on the following days with the following | F 0757 | F757<br>1) The Physician's orders for checking blood sugars and administration of insulin on sliding scale for Residents 18 and 21 were clarified by the physician and the Fingerstick and Insulin Administration form reviewed to ensure it matched. Resident 18 and 21 are having blood sugars checked and insulin administered per sliding scale as ordered.<br><br>2) Physician's orders and corresponding documentation records were reviewed for all residents with sliding scale insulin orders and clarified as needed.<br><br>3) Licensed nursing staff were inserviced on administration and documenting physician's orders for medication and corresponding documentation records, for residents with sliding scale insulin on<br>5-17-19.<br><br>4) The Director of Nursing or | 05/29/2019 |

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| | amount of Units:<br><br>4/13/19 - 4 Units<br>4/16/19 - 2 Units<br>4/22/19 - 2 Units<br><br>An interview was conducted with the DON (Director of Nursing) on 4/29/19 at 9:55 a.m. She reviewed Resident 21's April Fingerstick & Insulin Administration Form and acknowledged Resident 21 received sliding scale Humalog on the above dates, but shouldn't have.<br>2. The clinical record for Resident 18 was reviewed on 4/23/18 at 1:00 p.m. The diagnosis for Resident 18 included, but was not limited to, type 2 diabetes mellitus.<br><br>A physician order dated 11/10/17 indicated Resident 18 was to receive a sliding scale of novolog at 8:00 a.m., and 5:00 p.m. The sliding scale was the following:<br><br>151 blood sugar - 200 blood sugar = 2 units of insulin,<br>201 - blood sugar - 250 blood sugar = 4 units of insulin,<br>251 blood sugar - 300 blood sugar = 6 units of insulin,<br>301 blood sugar - 350 blood sugar = 8 units of insulin,<br><br>if blood sugar is less than 70 or greater than 350 the staff was to notify provider<br><br>A physician order dated 7/9/18 indicated Resident 18 was to receive 4 units of novolog twice a day.<br><br>A physician order dated 8/17/18 indicated Resident 18 was to receive 16 units of levemir at bedtime. | | designee will monitor the medication administration records daily for two months and weekly for four months; and document findings on the MAR/TAR documentation audit form, to ensure administration and documentation is complete. The findings will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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A "MD Problems/Notification dated 2/15/19 indicated "...Problem: Received N.O. (new order) for Resident's (Resident 18) increase of novolog from 4 units before meals 3 x (times) a day to 8 units before 3 x day; Would you like to keep sliding scale BID (twice a day) at 8AM (sic) and 5pm only or change it please clarify..."

A physician order for Resident 18 dated 3/30/19 indicated "..Order Clarification: 1. novolog 100 unit/ml (milliliter) - inject 8 unit SQ (in skin) TID (three times a day) before meals 2. Novolog 100 unit/ml - inject sq @ 8AM and 5pm only per sliding scale...3. levemir 100 unit/ml - inject sq 20 units every noc (night) @ bedtime. 4. BS (blood sugar) QID (four times a day)..."

The December 2018 "Fingerstick and Insulin Administration Form" for Resident 18 indicated the following days and times Resident 18 received additional dosages of the sliding scale not as ordered:

12/1/18 - 11:00 a.m., 4 units,
12/2/18 - 11:00 a.m., 4 units,
12/6/18 0 9:00 p.m., 4 units,
12/7/18 - 11:00 a.m., 4 units,
12/8/19 0 11:00 a.m., 4 units,
12/15/18 - 9:00 p.m., 8 units,

The January 2019 "Fingerstick and Insulin Administration Form" for Resident 18 indicated the following days and times Resident 18 received additional dosages of the sliding scale not as ordered:

1/1/19 - 9:00 p.m., - 6 units,
1/2/19 - 9:00 p.m., - 2 units,
1/3/19 - 9:00 p.m., - 4 units,

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| | 1/4/19 - 9:00 p.m., - 4 units,<br>1/5/19 - 9:00 p.m., - 4 units,<br>1/6/19 - 9:00 p.m., - 2 units,<br>1/7/19 - 9:00 p.m., - 4 units,<br>1/8/19 - 9:00 p.m., - 6 units,<br>1/9/19 - 9:00 p.m., - 4 units,<br>1/10/19 - 9:00 p.m., - 4 units,<br>1/11/19 - 9:00 p.m., - 6 units,<br>1/12/19 - 9:00 p.m., - 4 units,<br>1/14/19 - 9:00 p.m., - 4 units,<br>1/15/19 - 9:00 p.m. - 4 units,<br>1/16/19 - 9:00 p.m., - 6 units,<br>1/17/19 - 9:00 p.m., 6 units,<br>1/18/19 - 9:00 p.m., - 2 units,<br>1/19/19 - 9:00 p.m., - 2 units,<br>1/20/19 - 9:00 p.m., - 2 units,<br>1/21/19 - 9:00 p.m., - 8 units,<br>1/22/19 - 11:00 a.m., - 2 units and 9:00 p.m., 8 units,<br>1/23/19 - 9:00 p.m., - 4 units,<br>1/24/19 - 9:00 p.m., -4 units,<br>1/25/19 - 9:00 p.m., - 6 units,<br>1/26/19 - 9:00 p.m., - 6 units,<br>1/27/19 - 9:00 p.m., - 4 units,<br>1/28/19 - 9:00 p.m., - 6 units,<br>1/29/19 - 9:00 p.m.,- 6 units,<br>1/30/19 - 9:00 p.m., - 8 units,<br>1/31/19 - 9:00 p.m., - 8 units,<br><br>The February 2019 "Fingerstick and Insulin Administration Form" for Resident 18 indicated the following days and times Resident 18 received additional dosages of the sliding scale not as ordered:<br><br>2/1/19 - 9:00 p.m., - 4 units,<br>2/2/19 - 9:00 p.m., - 6 units,<br>2/3/19 - 9:00 p.m., - 6 units,<br>2/4/19 - 9:00 p.m., - 6 units,<br>2/5/19 - 9:00 p.m., - 6 units,<br>2/6/19 - 9:00 p.m., - 6 units, | | | |

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| | 2/7/19 - 9:00 p.m., - 8 units,<br>2/8/19 - 9:00 p.m., - 2 units,<br>2/9/19 - 9:00 p.m., - 6 units,<br>2/11/19 - 9:00 p.m., - 6 units,<br>2/12/19 - 9:00 p.m., - 6 units,<br>2/13/19 - 9:00 p.m., - 4 units,<br>2/14/19 - 9:00 p.m., - 4 units,<br>2/15/19 - 9:00 p.m., - 6 units,<br>2/16/19 - 9:00 p.m., - 4 units,<br>2/18/19 - 9:00 p.m., - 8 units,<br>2/19/19 - 11:00 a.m., - 6 units and 9:00 p.m., - 8 units,<br>2/20/19 - 9:00 p.m., - 6 units,<br>2/21/19 - 9:00 p.m., - 2 units,<br>2/22/19 - 9:00 p.m., - 2 units,<br>2/23/19 - 9:00 p.m., - 4 units,<br>2/24/19 - 9:00 p.m., - 2 units,<br>2/25/19 - 9:00 p.m., - 2 units,<br>2/26/19 - 9:00 p.m., - 4 units,<br>2/27/19 - 9:00 p.m., - 6 units,<br>2/28/19 - 9:00 p.m., - 8 units,<br><br>The March 2019 "Fingerstick and Insulin Administration Form" for Resident 18 indicated the following days and times Resident 18 received additional dosages of the sliding scale not as ordered:<br><br>3/1/19 - 11:00 a.m., - 8 units,<br>3/2/19 - 9:00 p.m., - 4 units,<br>3/3/19 - 9:00 p.m., - 4 units,<br>3/4/19 - 9:00 p.m., - 8 units,<br>3/5/19 - 9:00 p.m., - 4 units,<br>3/6/19 - 9:00 p.m., - 8 units,<br>3/7/19 - 9:00 p.m., - 2 units,<br>3/8/19 - 9:00 p.m., - 4 units,<br>3/9/19 - 9:00 p.m., - 6 units,<br>3/21/19 - 9:00 p.m., - 4 units,<br>3/22/19 - 11:00 a.m., - 8 units,<br>3/23/19 - 9:00 p.m., - 2 units, | | | |

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| | 3/24/19 - 9:00 p.m., - 4 units,<br>3/29/19 - 9:00 p.m., - 8 units,<br>3/30/19 - 9:00 p.m., - 2 units,<br><br>The April 2019 "Fingerstick and Insulin Administration Form" for Resident 18 indicated the following days and times Resident 18 received additional dosages of the sliding scale not as ordered:<br><br>4/12/19 - 11:00 a.m., - 2 units,<br>4/17/19 - 11:00 a.m., - 4 units,<br><br>An interview was conducted with the Assistant Director of Nursing (ADON) on 4/25/19 at 10:32 a.m. She indicated Resident 18 should only be receiving the novolog sliding scale at 8:00 a.m., and 5:00 p.m., twice a day. It was written on the "Fingerstick and Insulin Administration Form" when the staff should administer sliding scale novolog. The extra dosages of novolog was administered in error. It had been like since I believe November 2018. If Resident 18 had blood sugars over 350 the staff would notify the medical provider to receive an order to give additional dosages. There were no documented orders or nursing notes the medical provider ordered to give Resident 18 additional dosages of the novolog sliding scale.<br><br>3.1-48(a)(1)(6) | | | |
| F 0790<br>SS=D<br>Bldg. 00 | 483.55(a)(1)-(5)<br>Routine/Emergency Dental Srvcs in SNFs<br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility- | | | |

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| | §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br><br>Based on interview and record review the facility failed to assure dental services were received timely for 1 of 1 resident reviewed for dental care (Resident 20). | F 0790 | F790<br>1) Resident #20 has been referred to a dentist for evaluation.<br><br>2) There are no other residents pending dental services currently. | 05/29/2019 |

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| | Findings include:<br><br>The clinical record for Resident 20 was reviewed on 4/22/2019 at 3:30 p.m. The diagnosis for Resident 20 included, but were not limited to, generalized anxiety disorder and alcohol dependency.<br><br>An Admission MDS (Minimum Data Set) Assessment completed 1/21/2019, indicating Resident 20 was cognitively intact.<br><br>During an interview on 4/22/2019 at 3:23 p.m., Resident 20 indicated that he had asked to see the dentist due to his teeth being in bad shape and he had not seen a dentist since he had been at the facility.<br><br>The clinical record contained a care plan, which was initiated on 1/30/2019, indicating Resident 20 had dental health problems related to an abscess on the upper left gum area. The interventions included to schedule a dental appointment for follow up on the gum abscess.<br><br>The clinical record did not contain any consultation notes from a dentist.<br><br>On 4/25/2019 at 3:15 p.m., the Administrator provided a dental appointment list for 2/20/2019. Resident 20 was not included on the list of dental appointments.<br><br>During an interview on 4/29/2019 at 11:31 a.m., the Director of Nursing indicated the dentist would have only examined residents who were included on the dental appointment list. She indicated Resident 20 should have been added to the list to be seen. | | 3) Social Services will post Dentist visits well in advance on the facility information bulletin board. As the date of the Dentist visit draws near, Social Services will circulate a referral list to be completed by staff and or resident so resident can be seen on the day of visit. If a resident prefers services by an outside practitioner, Social Services will arrange the appointment and transportation for the resident. The name and contact information of the Dentist is included in the resident admission packet and posted in the facility. Social Services shall keep an Ancillary Services Provider Log for residents scheduled to be seen and when; services provided during the visit; and any pending work that needs to be done and/or follow up, e.g. “dentures ordered” or “extraction scheduled”. Social Services was inserviced on provision of dental services and maintaining the Provider Log on 5-10-19. All staff were inserviced on the provision of dental services and the referral process on 5-10-19.<br><br>4) Administrator will monitor the provision of dental services by reviewing the Log weekly for 3 months and monthly for six months. The findings will be reviewed monthly by the QAPI committee overseen by the | |

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| | On 4/29/2019 at 9:00 a.m., the Region Administrator provided the Ancillary Services Policy. The policy read as follows: "Policy: It is the policy of this facility to provide services including but not limited to: podiatry, optometry, audiology, dental and psych services to meet the residents highest physical, social, and psychosocial well-being at the facility. Procedure: 1. Social Services will maintain an ongoing list of residents who need or desire ancillary services based off of admission consent forms, resident interviews ..."<br><br>3.1-24(a) | | administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0812 SS=F Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. | | | |

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| | Based on observation, interview and record review the facility failed to ensure the dishwashing machine reached appropriate temperatures and had an easily readable label with manufactures recommendations, ensure appropriate freezer temperatures and assure proper labeling and storage of food items for 1 of 1 kitchen observed. This deficient practice had the potential to affect 27 of 27 who received meals from the kitchen.<br><br>Findings include:<br><br>1. The facility kitchen was observed on 4/26/2019 at 9:10 a.m. The Dietary Manager ran the dishwasher through the wash cycle 4 times. The temperature of the water in the dish machine did not reach 120 degrees Fahrenheit during any of the wash cycles. The highest temperature reached during the wash cycle was 105.8 degrees Fahrenheit. The label on the dishwasher with the manufactures recommendations for operation was unreadable.<br><br>During an interview on 4/26/2019 at 9:20 a.m., the Dietary Manager indicated the label on the dishwasher was worn and hard to read. The dishwasher was a low temperature chemical machine. He indicated that the temperature of the water should reach 120 degrees Fahrenheit.<br><br>On 4/25/2019 at 3:58 p.m., the Dietary Manager provided the April 2019 Food Contact Surface Cleaning and Sanitizing Log. There were no recorded wash temperatures for the following days and times: 4/1/2019 a.m. wash temperature, 4/2/2019 a.m. wash temperature, 4/4/2019 p.m. wash temperature, 4/6/2019 a.m. wash temperature, 4/16/2019 a.m. or p.m. wash temperatures, 4/17/2019 p.m. wash temperature, 4/18/2019 p.m. | F 0812 | F812<br>1) 2) All residents have the potential to be affected by the deficient practice. A) Once discovered, the operation of the dishmachine was suspended until the temperature during the wash cycles reached the manufacturer's recommended 120 degrees Fahrenheit. In the interim, residents were served with disposable products and other utensils and cookware were safely washed and sanitized in the three-compartment sink. The source water heater was adjusted, and temps were within the 120-degree Fahrenheit mark before the survey was completed. B) The bottle of barbecue sauce observed open and not refrigerated was disposed of immediately. The dry storage room was immediately inspected for any open containers which required refrigeration and none were found. C) The biscuit dough observed without a label and date was disposed of immediately. An inspection found all other items dated and labeled. D) The items in the standup freezer were frozen solid so there was no need to dispose of those immediately and, upon further investigation and cleaning of the condenser unit, the freezer quickly registered zero degrees Fahrenheit.<br><br>3) The Dietary staff was inserviced | 05/29/2019 |

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| | wash temperature and 4/19/2019 p.m. wash temperature.<br><br>On 4/25/2019 at 10:04 a.m., the Region Administrator provided the Recording Temperatures of Dish Machine Policy, dated 6/2018, which read as follows: " Policy: It is necessary to ensure that appropriate temperatures are maintained in the dish machine for proper cleaning and sanitizing, Procedure: ...3. Minimum temperatures are generally as follows but Manufacture's Guidelines are to be followed explicitly: ...Low Temperature Machines: Need to follow specific manufacturer guidelines..."<br><br>On 4/26/2019 at 8:48 a.m., the Dietary Manager provided the manufactures recommendations for the facilities dishwasher, which indicated the recommended minimum water temperature was 120 degrees Fahrenheit.<br><br>2. The facility kitchen was observed on 4/22/2019 at 10:10 a.m. The dry storage area contained a bottle of barbeque sauce, dated 4/02/2019, and the manufactures seal had been broken. It was 3/4 full. The label on the bottle stated refrigerate after opening.<br><br>During an interview on 4/22/2019 at 10:15 a.m., the Dietary Manager indicated that the bottle was open and the barbeque sauce had been used. The barbeque sauce should have been refrigerated after opening.<br><br>3. The facility pantry was observed on 4/22/2019 at 10:20 a.m. The freezer had a clear plastic bag that contained a dough like substance. There was no label or date on the plastic bag. The Dietary manager indicated the plastic bag contained biscuit dough. He indicated it should have been | | on 5-1-19 regarding the following: The Food and Nutrition policy regarding Dish Machine Operation – Low Temperature, the policy on Storage of Foods Under Sanitary Conditions, and labeling and dating food items. Dish Machine temps and Freezer Refrigerator temps will be documented daily. The Dietary Manager will use the kitchen sanitation QAPI audit to monitor storage of foods, dish machine function, and freezer temps.<br><br>4) The Dietary Manager will audit daily for one month and weekly for five months and ongoing. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | labeled and dated.<br><br>4. The facility kitchen was observed on 4/25/2019 at 3:00 p.m. The thermometer in the standup freezer, which contained multiple packages and boxes of frozen food, read 10 degrees Fahrenheit. .<br><br>During an interview on 4/25/2019 at 3:10 p.m., the Dietary Manager indicated that the freezer temperatures were usually around 10 degrees Fahrenheit. The temperatures fluctuated often due to putting items in and out of the freezer. The freezer temperature should be at 0 degrees Fahrenheit.<br><br>On 4/25/2019 at 3:30 p.m., the Dietary Manager provided the April 2019 temperature tracking log for the standup freezer. The temperature tracking log read as follows: 4/23/2019 a.m. freezer temperature of 7 degrees, p.m. freezer temperature 5 degrees, 4/24/2019 a.m. freezer temperature of 2 degrees, p.m. freezer temperature 6 degrees, 4/25/2019 a.m. freezer temperature of 2 degrees, p.m. freezer temperature of 10 degrees.<br><br>On 4/26/2018 at 8:48 a.m., the Dietary Manager provided the Equipment Temperatures Policy, dated 6/2018. The policy read as follows: "Policy: Temperatures of food storage equipment are critical to keeping refrigerated/ frozen foods within safe parameters. Procedure: 2. Freezer temperatures should be at or below 0 degrees Fahrenheit..."<br><br>3.1-21(i)(2)<br>3/1-21(i)(3) | | | |
| F 0867<br>SS=E<br>Bldg. 00 | 483.75(g)(2)(ii)<br>QAPI/QAA Improvement Activities<br>§483.75(g) Quality assessment and | | | |

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| | assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>Based on interview and record review, the facility failed to identify, implement and monitor corrective actions put in place to ensure effectiveness of QAPI plan for abuse, abuse reporting and investigations (Residents 6, 7, 19, 5, 20, and 21), kitchen sanitation and infection control program with potential to affect 27 of 27 residents residing in the building and the antibiotic stewardship program for 11 of 11 (Residents 3, 11, 14, 16, 17, 22, 23, 26, 76, 77, 78) residents reviewed for antibiotic stewardship.<br><br>Findings include:<br><br>An interview was conducted with the Region Administrator (RA), Director Of Nursing (DON) and Nurse Consultant (NC) 1 on 4/29/19 at 1:44 p.m. The RA, DON and NC 1 all indicated they did not regularly attend the QAPI (Quality Assurance Performance Importance) meetings. The DON indicated the QAPI committee does meet monthly. The staff that attend the meetings are the Medical Director, DON, Administrator, pharmacist and Social Services Director. The DON and Certified Nursing Assistant (CNA) 4 had just taken over the roles of the Director of Nursing and Social Services Designee, so they had not yet attended a QAPI meeting. The DON indicated allegations abuse were discussed daily in morning meetings. NC 1 indicated she was unsure if abuse was discussed in QAPI since she had not attended, but she does know abuse inservicing recently had been conducted to the staff. NC 1 | F 0867 | F867<br>1) To ensure the effectiveness of the QAPI Plan, the facility has identified and implemented a corrective action plan, and will monitor corrective actions through the QAPI program for the following:<br><br>A) F600, F609, F610 Failure to ensure residents were free from physical and verbal abuse; Failure to report and timely report verbal and physical abuse to the Indiana State Department of Health, and report physical and verbal abuse timely to the Administrator; and, Failure to thoroughly investigate allegations of abuse per policy (Residents 6, 7, 19, 5, 20 and 21).<br>B) F812 Failure to ensure the dishwashing machine reached appropriate temperatures and had an easily readable label with manufacturer's recommendations (All Residents).<br>C) F880 Failure to ensure infection control tracking was in place for 1 of 4 months (All Residents).<br>D) F881 Failure to promote antibiotic stewardship by not following the McGreer Criteria (process for defining healthcare | 05/29/2019 |

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| | indicated she also had identified the infection tracking log was not being completed. She had educated the previous DONs on how to track and log the infection control log, but the DON position has had a few turnovers recently. The RA indicated the QAPI meetings conducted do discuss significant changes, med storage, kitchen, weight loss, medication errors, antibiotic stewardship, abuse, and infection tracking program. The RA was confident abuse allegations were investigated by the Administrator, but unable to provide evidence of documented investigations. He indicated the pharmacist did recognize the lack of logging not completed with Infection Control tracking and antibiotic stewardship. The pharmacist suggested to further develop. The DON indicated the Social Services Director had terminated her position in March, and the facility had immediately started using a Social Services Consultant monthly. The residents have never been without one. The Social Services Consultant had started coming in as of last week on a weekly basis.<br><br>The 2018/2019 QAPI PLAN was provided by the RA on 4/25/19 at 10:25 a.m. It indicated "...Our Vision: The vision of (name of facility) is to create an environment where residents are wrapped in compassion to help each resident live life to the fullest...QAPI will provide a continuous, systematic, comprehensive and data driven approach to daily operations which monitors the overall environment of the community and ensures the highest quality of care is provided while opportunities for improvement are identified...Our Plan: ..Our QAPI Plan includes policies and procedures that describe how organization will: Identify and use data to monitor performance; Establish goals and thresholds for performance measure; Utilize and prioritize | | associated infections for surveillance) (Residents 3, 11, 14, 16, 17, 22, 23, 26, 76, 77, 78).<br><br>2) All deficient practices cited during the most recent survey have been identified and the facility has implemented corrective action plans; and will monitor corrective actions through the QAPI program to ensure the effectiveness of the organization's QAPI Plan.<br><br>3) The Administrator is the QAPI coordinator and is responsible for the development and implementation of the QAPI Plan. The interdisciplinary QAPI committee will meet monthly. Items for presentation to the QAPI committee include but not limited to benchmark reports, audits, quality measure reports and ISDH survey results. Areas to be reviewed monthly include but not limited to Falls, High Risk Events, Pharmacy, Infection Control, Abuse, and Kitchen Sanitation. The Administrator and Interdisciplinary team were inserviced regarding the organization's QAPI Plan and program on 5-1-19 .<br><br>4) To monitor compliance, the Administrator will submit minutes of the QAPI meeting to regional and senior management monthly for review to ensure all elements of | |

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| | problems and opportunities for improvement; Systematically analyze underlying causes of systemic problems and adverse events; Develop corrective action or performance improvement activities; and Utilize best available evidence..."<br><br>1. Abuse<br><br>The facility was found to not be implementing 3 components of their abuse policy. The following components of abuse had the following concerns: 5 of 8 residents reviewed for abuse and reporting abuse (Resident 6, 7, 5, 19 and 20) and 4 of 6 residents reviewed for investigating abuse (Resident 21, 19, 20, and 5)<br><br>An "Abuse Prevention" policy was provided by the Region Administrator on 4/25/19 at 10:42 a.m. It indicated "...It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program: ...III. Preventing Resident Abuse Policy Statement. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...V. Abuse Investigations. Policy Statement. All reports of residents abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Policy Interpretation and Implementation...2. Should an incident or suspected incident of | | the QAPI plan are being addressed for six months and ongoing. The review will include the corrective action plans and the expected monitoring of those plans to correct the deficient practices cited during the most recent survey, including:<br><br>A) A continuous sample of residents will be interviewed using QIS abuse questions tool by the social worker weekly for three months and bi-monthly thereafter for six months. Administrator or designee will conduct employee stand up tests/education weekly for three months and bi-weekly thereafter for three months; and, all staff education will be conducted bi-monthly for six months. The abuse IRI audit tool will be used bi-monthly for six months. If any concerns are identified, facility staff will ensure the resident is protected, the allegation is reported, and the allegation is thoroughly investigated by the Administrator. The results of these audits will be reviewed by the QAPI committee and forwarded to corporate compliance. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.<br>B) The Dietary Manager will use the kitchen sanitation QAPI audit to monitor dish machine function daily for four weeks, and weekly | |

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| | resident abuse, neglect, or injury of an unknown source be reported to the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 3. The individual conducting the investigation will, at a minimum: a. Review the resident's medical record to determine events leading up to the incident; b. Interview the person(s) reporting the incident; c. Interview any witness to the incident; d. Interview the resident (as medically appropriate); e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. f. Interview the resident's roommate, family members, and visitors;...9. A copy of the completed investigation will be maintained in the facility in a confidential file..."<br><br>An interview was conducted with the Administrator on 4/23/19 at 12:30 p.m. She indicated the investigations are done in the computer. She used paper and pencil to conduct the investigations when they were interviewed face to face. She then takes her notes and types them on the computer. After, the pieces of paper are then shredded. She also tries to have residents fill out grievance forms to write up his or her allegations, but unable to provide any resident or staff statements for investigations from computer or grievance forms. She was reporting the follow ups on the incident reports prior to being finished. The Administrator determined abuse by individual circumstances. If a resident called another resident an offensive name that would be considered abuse, but just to use foul language in conversation was not. The building was unique, and with some residents' cursing was his or her type of communication.<br><br>An interview was conducted with the Region Administrator on 4/25/19 at 10:40 a.m. He | | for six months and ongoing. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.<br>C) The Administrator and or the Regional Nurse Consultant will review the Infection Control log weekly for six months to ensure completion and will document findings on the Infection Control Log audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.<br>D) The Administrator and or Regional Nurse Consultant will review the Infection Control Log weekly for six months to ensure antibiotic tracking and use of the McGreer Criteria are current and ongoing. Findings will be documented on the Infection Control Log audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | indicated the Administrator was supposed to send reportable's to multiple people in corporate prior to submitting them to the state, and the Administrator should know that.<br><br>Cross reference tags 600, 609 and 610<br><br>2. Kitchen Sanitation:<br><br>The facility kitchen was observed on 4/26/2019 at 9:10 a.m. The Dietary Manager ran the dishwasher through the wash cycle 4 times. The temperature of the water in the dish machine did not reach 120 degrees Fahrenheit during any of the wash cycles. The highest temperature reached during the wash cycle was 105.8 degrees Fahrenheit. The label on the dishwasher with the manufactures recommendations for operation was unreadable. There were multiple dates logged where the temperature did not meet the 120 degree Fahrenheit as the policy and manufacturer required.<br><br>Cross reference with F812<br><br>3. Infection Control:<br><br>The infection control logs from December, 2018 through March, 2019 were provided by the DON (Director of Nursing) on 4/29/19 at 11:10 a.m. The logs did not include any information for February, 2019.<br><br>An interview was conducted with NC (Nurse Consultant) 1 on 4/29/19 at 11:41 a.m. She indicated the previous DON quit in February, 2019, so the infections were not tracked that month.<br><br>The Infection Prevention and Control policy was | | | |

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| | provided by the Administrator on 4/24/19 at 10:49 a.m. It read, "Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications....Data gathered during surveillance is used to oversee infections and spot trends."<br><br>4. Antibiotic Stewardship:<br><br>C. The facility was not implementing and monitoring corrective actions in place to ensure Antibiotic Stewardship was being conducted in the facility for 11 of 11 residents were on antibiotic therapy without indication criteria for use. Residents (Residents 3, 11, 14, 16, 17, 22, 23, 26, 76, 77, 78).<br><br>Cross reference with F881<br><br>3.1-52 | | | |
| F 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | | | |

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| | §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident | | | |

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| | contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review and interview, the facility failed to ensure infection control policies were followed for contact isolation for one of one residents reviewed for contact isolation (Resident 22), glucometer testing for 3 of 3 residents observed for blood glucose monitoring (Resident 14, 10 and 18) and infection control tracking was in place for 1 of 4 months reviewed. This deficient practice had the potential to affect 27 of 27 residents residing in the facility.<br><br>Findings include:<br><br>1a. A Record review on 4/22/19 at 12:27 p.m., of Resident 22's chart indicated an order written on 3/30/19 to initiate isolation precautions.<br><br>A Final lab report for Resident 22, dated 3/30/19, indicated a positive result for ESBL in her urine.<br><br>On 4/22/19 at 12:28 p.m., an observation of Resident 22's door lacked isolation signage and there was not an isolation supply cart near the door. Two residents shared this room. | F 0880 | F880<br>1) A) When it was discovered resident 22 had no order for a follow up urine culture and none had been completed, an order was received to place the resident back on contact isolation and obtain a urinalysis with culture and sensitivity. An isolation supply cart was placed outside the room and exterior signage posted. Resident 22 remains on contact isolation and appropriate precautions are being taken. B) As soon as facility was aware QMA 4 was not following the directions for use on the sani-wipes container when cleaning the glucometer after testing residents 14, 10 and 18, QMA was inserviced on the spot as to directions for use of the sani-wipe product. QMA 4 was also inserviced on contact | 05/29/2019 |

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| | In an interview, on 4/22/19 at 2:46 p.m., the DON (Director of Nursing) indicated, a repeat urine culture was needed to confirm a negative result for ESBL prior to discontinuation of contact isolation precautions. Additionally, there should be an order from the physician to discontinue the isolation precautions. The ADON (Assistant Director of Nursing) and DON reviewed the electronic and paper chart at the same time as interview. The DON indicated at this time, there wasn't an order for the urine culture and no further urine cultures had been completed since 3/27/19. DON stated, "the resident should be in contact isolation currently, I will place resident back in contact isolation and will need to change residents room since she has a roommate".<br><br>On 4/23/19 at 11:45 a.m., a record review indicated a new order dated 4/23/19 at 11:45 a.m., indicated to obtain a Urinalysis with culture and sensitivity to rule out infection. The order also indicated to place resident in contact isolation.<br><br>The Transmission-Based Precaution policy, received on 4/24/19 at 10:49 a.m. from the Administrator, indicated, "....5. Transmission-Based Precautions shall remain in effect until the attending physician or Infection Preventionist discontinues them, which should occur after pertinent criteria for discontinuation are met..."<br><br>1b. On 4/23/19 at 12:15 p.m., QMA 4 walked into Resident 22's room without donning gown or gloves, administered medications to the resident and exited the room and walked across the hall to wash her hands. At that time during interview, QMA 4 indicated the resident was in isolation for ESBL, but because it's in the residents urine and | | precautions gown and glove procedure; and the steps for handwashing and donning and doffing gloves during glucometer disinfecting procedure. C) An infection control log for May is being maintained including reporting and tracking infections.<br><br>2) Surveillance tools are in place to recognize the occurrence of infections, recording the number and frequency, detecting outbreaks and epidemics, monitoring infections, tracking and detecting trends. The Director of Nursing was inserviced on the Infection Prevention and Control Policy including the Infection Control Log on 5-2-19.<br><br>3) All staff were inserviced on 5-9-19 regarding contact isolation procedures. The licensed nursing staff and QMAs were inserviced on contact isolation procedures as it relates specifically to their tasks including but not limited to taking vital signs, administering medications, and treatments on 5-9-19. The licensed staff and QMAs were inserviced on 5-9-19 regarding sanitizing the glucometer and steps for handwashing and donning and doffing gloves before and after glucometer testing and sanitizing. The facility is planning to provide individual glucometers for residents whose blood sugar is | |

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| | she was not coming in contact with the urine, she did not need to gown and glove prior to entering the room.<br><br>On 4/23/19 at 12:18 p.m., during interview, the DON indicated if resident was on contact precautions, regardless of where the infection was located, then all staff entering the room needed to gown and glove prior to entry in the room. DON indicated QMA 4, should have gowned and gloved prior to entering the room.<br><br>2a. On 4/25/19 at 11:28 a.m., QMA 4 was observed to exit resident 14's room after completing a glucose test. She then wiped the front of the glucometer for 30 seconds with a Sani-wipe, back for 30 seconds with a new Sani-wipe, and each side for 30 seconds with a new Sani-wipe. She then placed the meter on facial tissue, removed dirty gloves and performed hand hygiene.<br><br>2b. On the same day at 11: 32 a.m., QMA 4 was observed to exit Resident 10's room; removed dirty gloves, donned a single glove, wiped the front of glucometer for 30 seconds with a Sani-wipe, back for 30 seconds with a new Sani-wipe, and each side for 30 seconds with a new Sani-wipe; removed single glove; performed hand hygiene.<br><br>2c. The same day at 11: 43 a.m., QMA 4 was observed to exit Resident 18's room; wiped front of glucometer for 30 seconds with a Sani-wipe, back for 30 seconds with a new Sani-wipe, and each side for 30 seconds with a new Sani-wipe; removed gloves; then washed her hands.<br><br>During an interview with QMA 4 on 4/25/19 at 11:53 a.m., she indicated, if she washed each side | | being monitored.<br><br>4) An isolation surveillance team consisting of the Administrator, Director of Nursing and charge nurse(s) will observe isolation practices (rotating shifts) daily for four weeks, and weekly using the same methodology for five months. Findings will be recorded on the Isolation Surveillance audit form. The Director of Nursing and/or designee will observe glucometer use and sanitation daily (rotating shifts and observing different personnel) for four weeks, and weekly using the same methodology for five months. Findings will be recorded on the Glucometer Testing audit form. The Administrator and or the Regional Nurse Consultant will review the Infection Control log weekly for six months to ensure completion and will document findings on the Infection Control Log audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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of the glucometer for 30 seconds with a new Sani-wipe for a total time of 2 minutes, the glucometer was disinfected and ready for use on the next resident. She was not aware of the directions for disinfection listed on sani-wipes container.

On 4/25/19 at 12:17 p.m., during interview, DON indicated the procedure for cleaning glucometers was to use the purple sani-wipes to clean/disinfect the meters in between each resident and the glucometer must be allowed to air dry. The DON was unaware of the directions for disinfection using the Sani- wipes.

On 4/26/19 at 9:43 a.m., the directions for Sani wipes was reviewed with the DON, which indicated, " Super Sani-Cloth Germicidal disposable Wipe Directions for disinfection: To disinfect nonfood contact surfaces only; Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let air dry... All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil...Use second germicidal wipe to thoroughly wet surface. Allow to remain wet two (2) min, let air dry..."

The Nursing Policy, received from Nurse Consultant 2, on 4/26/19 at 2:19 p.m., indicated, "....7. Remove gloves and wash hands prior to exiting room...10. Cleanse the glucometer with the disinfectant wipe...12. Allow device to air dry for minimum of five minutes or per manufacturer recommendations. 13. Wash hands or use alcohol gel as appropriate..."3. The infection control logs from December, 2018 through March, 2019 were provided by the DON (Director of Nursing) on

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| | 4/29/19 at 11:10 a.m. The logs did not include any information for February, 2019.<br><br>An interview was conducted with NC (Nurse Consultant) 1 on 4/29/19 at 11:41 a.m. She indicated the previous DON quit in February, 2019, so the infections were not tracked that month.<br><br>The Infection Prevention and Control policy was provided by the Administrator on 4/24/19 at 10:49 a.m. It indicated, "Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications....Data gathered during surveillance is used to oversee infections and spot trends."<br><br>3.1-18(b)(1)(A)<br>3.1-18(b)(2)<br>3.1-18(l) | | | |
| F 0881 SS=E Bldg. 00 | 483.80(a)(3)<br>Antibiotic Stewardship Program<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>Based on interview and record review, the facility failed to promote antibiotic stewardship by not following the McGreer's criteria (process for defining healthcare associated infections for | F 0881 | F881<br>1) 2) All current residents with antibiotics are being tracked and have been assessed to determine | 05/29/2019 |

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| | Surveillance) for 11 of 11 residents reviewed for antibiotic therapy (Residents 3, 11, 14, 16, 17, 22, 23, 26, 76, 77, 78).<br><br>Findings include:<br><br>The infection control logs from December, 2018 through March, 2019 were provided by the DON (Director of Nursing) on 4/29/19 at 11:10 a.m. The logs did not include any information for February, 2019.<br><br>An interview was conducted with NC (Nurse Consultant) 1 on 4/29/19 at 11:41 a.m. She indicated the previous DON quit in February, 2019, so the infections were not tracked that month.<br><br>The monthly infection control logs included an Antibiotic Use Report with a section for assessing whether or not criteria was met for the antibiotic use. This section of the report was left blank for all months. The December, 2018 report indicated 6 residents on antibiotics. The January, 2019 report indicated 5 residents on antibiotics. The February, 2019 report was not completed. The March, 2019 report indicated 5 residents on antibiotics. The December 2018, January, 2019 and March, 2019 reports indicated a total of 11 residents on antibiotics. (Residents 3, 11, 14, 16, 17, 22, 23, 26, 76, 77, 78)<br><br>An interview was conducted with NC 1 on 4/29/19 at 11:41 a.m. She indicated the facility used the McGreer's criteria for assessing true versus not true infections. She indicated she explained to the previous DON how to go back and see if a resident met the McGreer's criteria. She indicated, ideally, they would include a resident on the list if they were on an antibiotic, then look at the criteria | | whether the antibiotics meet the McGreer Criteria. Attending physician is aware of findings.<br><br>3) Antibiotic stewardship will be an integral part of the Infection Control Program. Signs and symptoms, lab and x-ray results, and culture reports and sensitivity data will be utilized to determine whether antibiotic usage meets McGreer Criteria. The infection and antibiotic surveillance activities will be recorded in the Infection Control Log monthly. Trends, including the physician ordering the antibiotic will be tracked and physicians apprised of the results. The Director of Nursing and licensed nursing staff were inserviced on antibiotic stewardship, including surveillance activities and McGreer Criteria on 5-16-19.<br><br>4) The Administrator and or Regional Nurse Consultant will review the Infection Control Log weekly for six months to ensure antibiotic tracking and use of the McGreer Criteria are current and ongoing. Findings will be documented on the Infection Control Log audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | to see if the resident met it, and if not, inform the physician.<br><br>The January, 2019 Antibiotic Use Report indicated Resident 26 was on amoxicillin for 6 days with an indication of prophylaxis.<br><br>An interview was conducted with NC 1 on 4/29/19 at 11:41 a.m. She indicated prophylaxis did not meet the McGreer's criteria for antibiotic use, but it was not reviewed at the time to make that determination and inform the physician.<br><br>The Infection Prevention and Control policy was provided by the Administrator on 4/24/19 at 10:49 a.m. It read, "Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications....Antibiotic Stewardship a. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews." | | | |
| F 0921<br>SS=D<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview the facility failed to ensure a mattress was free of moisture damage for 1 of 1 resident reviewed for urinary incontinence (Resident 5). | F 0921 | F921<br>1) The Mattress for resident #5 was disposed of at the time of survey. | 05/29/2019 |

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| LAWRENCE MANOR HEALTHCARE CENTER | 8935 E 46TH ST<br>INDIANAPOLIS, IN 46226 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings include:<br><br>The clinical record for Resident 5 was reviewed on 4/22/2019 at 11:10 a.m. The diagnosis for Resident 5 included, but were not limited to, overactive bladder, bipolar disorder, and personality disorder.<br><br>A Quarterly MDS (Minimum Data Set) Assessment completed 2/13/2019, indicated Resident 5 was cognitively intact and she was frequently incontinent of bladder and bowel. She needed limited assist with toileting.<br><br>On 4/22/2019 at 10:32 a.m., Resident 5 was observed laying on her bed in her room. The room was noted to have a very strong urine odor.<br><br>On 4/22/2019 at 1:45 p.m., Resident 5's room was observed. There was a very strong urine odor and the bed was unmade. There were worn, pealing areas on the blue mattress protector. There was a brown substance which was smeared on the outer right outer edge of the mattress.<br><br>During an interview on 4/22/2019 at 2:26 p.m., the DON (Director of Nursing) indicated there was bowel movement present on the outside edge of the mattress.<br><br>During an interview on 4/22/2019 at 2:30 p.m., the ED (Executive Director) indicated the top the vinyl mattress protector was worn and there was a urine odor present in the room.<br><br>On 4/22/2019 at 2:40 p.m., the Maintenance Supervisor was observed lifting up the mattress. There was moisture noted under the mattress on the bed frame. The zipper of the mattress cover was opened and the mattress was observed to | | 2) An audit of all facility mattresses was completed, and exchanges made if needed.<br><br>3) Monitoring the condition of resident room mattresses has been added to the TELS preventative maintenance program. The administrator and maintenance supervisor established criteria for mattress replacement. Mattresses will be inspected monthly to ensure support and ability to be sanitized properly. If a mattress has lost its functional use and or can no longer be sanitized properly it will be replaced. Maintenance and housekeeping staff were inserviced on mattress integrity and the criteria for disposal on 5-1-19.<br><br>4) The maintenance person will inspect mattresses weekly for one month and monthly for five months and ongoing. Findings will be recorded on the mattress inspection audit form. The audits will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155721 | A. BUILDING 00<br>B. WING | 04/29/2019 |

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| | have multiple brown spots under the protective cover. The Maintenance Supervisor indicated that the spots were due to Resident 5 being incontinent in her bed and that some of the urine may have come through the mattress. He indicated the mattress needed to be replaced.<br><br>3.1-19(e) | | | |