STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

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F000000	This visit was for a Recertification and State Licensure Survey Survey Dates: October 15, 16, 17, 20, 21 and 22, 2014 Facility Number: 000030 Provider Number:155073 AIM Number: 100275260 Survey Team: Debora Kammeyer, RN-TL Julie Wagoner, RN Lora Swanson, RN Sharon Ewing, RN (October 15 & 20, 2014) Census Bed Type SNF: 6 SNF/NF: 51 Total: 57 Census Payor Type: Medicare: 8 Medicaid: 35 Other: 14 Total: 57 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F000000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during our Annual Health Survey conducted on October 22, 2014. I would like to formally request your consideration for granting this facility paper compliance. Hopefully, you will find the remedies are sufficient, thoroughly explained and able to provide a clear picture of how we corrected these concerns. The Medical Director has been consulted and has agreed with the plan of correction as submitted. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact Lori Smith, Administrator at 574-936-9943. Thank you.	

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

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	Quality Review completed on October 30, 2014, by Brenda Meredith, R.N.			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to ensure their abuse policy regarding the investigation process for an allegation of verbal abuse was followed for 1 of 2 abuse allegation investigations reviewed. This investigation involved Resident #8. Findings included: During an interview, with alert and oriented Resident #8, conducted on 10/16/14 at 11:20 A.M., the resident indicated a nursing assistant had "verbally abused" him. He indicated he had reported the issue to the Administrator and she had reported the issue to the "State." When questioned further regarding the abuse, the resident indicated the CNA had a "bad attitude"	F000226	1. Resident #8 was not affected by this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. The "Abuse Prevention Policy & Procedure" has been updated (See Exhibit 1). According to the type of allegation, severity, time frame of when it was reported and other contributing factors, there may be interviews conducted with staff, cognitively alert residents, family members, visitors, etc. The investigation will gather information to determine the root cause to allow changes to be made to protect all residents. 3. The "Abuse Prevention Policy & Procedure" has been updated (See Exhibit 1). According to the type of allegation, severity, time frame of when it was reported and other contributing factors, there may be interviews	11/20/2014

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	but could not be specific regarding what had been abusive about her verbalizations. A review of an Abuse Investigation was conducted on 10/17/14 at 12:15 P.M. - 12:30 P.M. The allegation of abuse involving Resident #8 and CNA #2, indicated on 07/28/14, Resident #8 reported to the DON (Director of Nursing) that CNA #2 had verbally abused him with her "attitude and tone"during the previous week. The allegation was reported to the Department of Health and other required entities on 07/28/14. The investigation, which was initiated on 07/28/14 and completed on 07/29/14 indicated CNA #2 and Resident #8 had a verbal altercation regarding his care requests on 07/25/14. The facility's investigation included documentation of an interview with Resident #8 and a statement written by CNA #2 regarding the altercation. The facility concluded CNA #2 had not followed their policy related to handling escalating situations and she was in-serviced again on two of the related policies and she was also removed from any care assignment for Resident #8. There were no other interviews documented in the investigative documentation.		conducted with staff, cognitively alert residents, family members, visitors, etc. The investigation will gather information to determine the root cause to allow changes to be made to protect all residents. The Administrator and/or Director of nursing will conduct most investigations. Nurses will be in-serviced on 11-12-14 through 11-14-14 on the investigation process. Examples: *A cognitively impaired resident makes physical contact with another cognitively impaired resident in the hall and was witnessed by 2 staff members. Both staff members would be interviewed. *Allegation of an employee raising their voice at a resident in the dining room. Staff, families and other cognitively alert residents, that were present, may be interviewed. *Resident alleged an Aide was rough when assisting her to bed. Staff in the vicinity when it occurred, anyone in the room at the time and other cognitively alert residents (randomly selected), that the accused employee has worked with, would be interviewed. 4. Monthly, all reportable incidents in regards to abuse, will be reviewed at the Monthly QA Committee meeting (See Exhibit 2). These meetings are attended by: Administrator, Director of Nursing, Unit Managers (2), MDS Coordinator, Staff Development Coordinator, Business Office	

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	An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an ongoing personality conflict between the		Manager, Social Service Director, Medical Records, Activity Director, Dietary Manager and Environmental Services Director. The Medical Director will receive copies of the Monthly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	

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	two individuals. Other staff were not interviewed because it was considered to be a 1 on 1 issue and more of a personality conflict. The CNA in question has never had any other complaints but did have a history of issues with this resident. The Ombudsman had even been in to try to do conflict resolution between the resident and this aide in the past. The aide would ask the resident to say "please" when he demanded things and this would upset the resident who insisted he did not have to say please. Review of the facility's policy and procedure, titled, Abuse Prevention Policy and Procedure, dated 04/15/11, and indicated as current by the DON, included the following procedures: "...V. Once an allegation has been made, the Director of Nursing or the Administrator will interview the resident and all staff members scheduled with the accused. Documentation will be kept of these interviews...." 3.1-28(a)			
F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES			

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	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interviews, the facility failed to ensure activities were provided as care planned for 1 of 3 residents reviewed for activities. (Resident #74) Finding includes: Resident #74 was observed, on 10/16/14 from 9:00 A.M. - 12:00 P.M. and 1:00 P.M. - 3:00 P.M., seated in her room in her recliner. She was awake for large portions of the time but did doze off and on. Resident #74 was observed, on 10/17/2014 at 2:03 P.M., sitting in a recliner beside her bed. Resident #74 was observed, on 10/17/2014 at 2:37 P.M., in her room, seated in her recliner, holding a word search book. She indicated she had already read the newspaper, which was folded on her bed. When asked about the Bingo activity, which was being held in the dining room, the resident seemed unaware of the activity and indicated she wanted to go to the activity. She	F000248	1. Resident #74's care plan (See Exhibit 3) and interests (See Exhibit 4) have been reviewed with her and have been updated . Activities will have reports made that identifies Resident #74's interest in each type of activity (See Exhibit 5). Prior to an activity, Activities will print the report and if Resident 74 is identified to be interested in that activity, she will be asked if she would like to attend. If she declines, attends, was sleeping, etc. will be documented in the Electronic Chart System (ECS) (See Exhibit 6). 2. All residents have the potential to be affected by this alleged deficient practice. Each resident's interest will be reviewed and their interests will be updated in ECS by 11-14-14. 3. Activites will have a report made that identifies each resident's interest in each type of activity (See Exhibit 5). Prior to an activity, Activities will print the report and attempt to invite each resident that is identified to be interested in that activity. If the resident declines, was sleeping, attended, etc. will be documented in ECS (See Exhibit 6). A policy/procedure has been developed "Activity Attendance & Record" will aide in inviting	11/20/2014

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	indicated no one had invited her to go to the activity. Nursing staff were notified and the resident was assisted to the activity. Resident #74 was observed, on 10/20/2014 at 10:48 A.M., sitting in her room in a recliner. Her daughter was visiting in the room. Resident #74's daughter indicated the resident had been to a craft activity over the weekend but had not made it to the painting activity because no one came and got her and the resident could not remember when activities were scheduled. The resident indicated she enjoyed going to activities. The facility was having an exercise activity in the front lounge, on 10/20/2014 at 10:59 A.M., but Resident #74 was not observed to participate in the activity. She was noted in her room, seated in the recliner beside her bed. The facility was scheduled to have a "Fancy Nails" activity at 1:00 P.M. on 10/20/14. At 1:25 P.M. on 10/20/14, there were three residents in the activity room who had their nails painted. Resident #74 was observed in her room, in her recliner, asleep. Her nails were not noted to have been manicured or painted. An interview, on 10/20/14 at 1:25 P.M., CNA #1 who was painting nails in the		residents to activities and documenting attendance of the activity (See Exhibit 7). Each week a report in ECS will be ran that identifies each activity interest and if the resident did not attend the activity that reflects their interests, it will flag on the report (See Exhibit 8). Activities can then evaluate why a resident did not attend and make any adjustments that may be needed. A policy/procedure has been developed "Activity Audits/Assessments/Care Plans" (See Exhibit 9), that describes the weekly audits and how they are to be reviewed. An in-service will be held for all Activity Staff on 11-15-14 through 11-18-14. 4. The Activity Director will report any residents who have needed to have an activity interest revised, due to the weekly audits, in the weekly QA committee meeting. (See Exhibit 10). The weekly QA committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2-Unit Managers, Staff Development Coordinator, Social Services Director, Business Office Manager, Medical Records, Activity Director, Dietary Manager and Environmental Services Director. The Medical Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask	

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	activity room, indicated she had started painting fingernails as soon as residents were done eating lunch. The facility was having exercises in the front lounge on 10/21/2014 at 11:06 A.M. There were at least 10 residents present. Resident #74 was sitting in her room in her recliner awake. She indicated she was not aware of the exercises activity but thought it might be too late to go to exercises now. She indicated she would have gone to activities this morning. She stated she especially enjoyed craft activities. Resident #74 was observed, on 10/21/2014 at 9:52 A.M., in her room awake. The television was on a music video channel but the volume was on mute. There was a cup of coffee on the resident's over bed table. Resident #74 was asked what she was going to do this morning and she seemed unaware of the Yahtzee activity. She indicated she was not sure she could remember how to play Yahtzee. As we were talking, the resident's pastor entered the room for a visit and had brought the resident some cookies. No staff were noted to invite the resident to participate in the Yahtzee activity prior to the pastor entering the resident's room. The facility's scheduled activities for the morning of 10/21/14		questions and voice concerns.	

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	were: coffee scheduled for 8:15 A.M. and Yahtzee at 10:00 A.M. There were three residents and two staff members noted in the activity room talking and drinking coffee at 10:05 A.M. The three residents and CNA #1 were then noted to play Yahtzee around 10:20 A.M. There was a "Scrap" craft activity scheduled on 10/21/14 at 1:00 P.M. Resident #74 did not attend the activity. The clinical record for Resident #74 was reviewed on 10/17/2014 at 12:14 P.M. Resident #74 was admitted to the facility on 08/22/14 with diagnosis, including but not limited to: aortic valve disorder, congestive heart failure, coronary artery disease, hypertension, dementia, anxiety, and end stage aortic valve disorder. Activity notes, dated 08/26/14, indicated the resident was very friendly and enjoyed reading in her room. The resident was looking forward to pet visits and enjoyed group activities and going outside. She also was a member of a church in the past. The activity attendance records from 10/10/14 - 10/17/14 indicated the resident had attended exercises, a craft activity, and Bingo on 10/10/14 but had only attended the soup serving just prior to the			

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	noon meal, read her newspaper in her room, and received a beverage in her room from the drink cart on a daily basis. The care plan related to activities, initiated on 09/03/14, for Resident #74 indicated the resident enjoyed participating in group activities and did independent activities in her room. The goal was for the resident to be involved in out of room activities, group activities and outings, independent activities 2 - 3 times a week. The interventions included encourage activity participation, assist to activities as needed, and assess interests and strengths and provide and review the activity calendar with the resident. During an interview, on 10/22/2014 at 9:30 A.M., The Activity Director indicated the resident did not attend the craft activity on 10/21/14 in the afternoon. She indicated when the resident was invited to an activity 1/2 hour prior to the activity she sometimes did not end up attending the activity. The activity director was unsure if it was a disconnect between activity staff and nursing staff, who would have to switch the resident's oxygen in order for the resident to be able to attend the activity or no one assisted and brought the resident to the scheduled activity. There was no reason given as to why the			

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	resident did not attend the craft activity. The Activity Director thought perhaps the resident was also forgetting the invitation to the activity and perhaps the activity assistant was not actually going back to to ensure the resident was assisted to many of the scheduled activities. 3.1-33(a)			
F000257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interviews, the facility failed to ensure a room temperature was within the acceptable parameters. This had the potential to affect 1 of 26 residents residing on the East hallway. (Resident #13) Finding includes: On 10/16/14 at 12:52 P.M., an interview with Resident #13 indicated her room was always hot causing her to run a fan at all times to keep cool. On 10/16/14 at 12:55 P.M., Resident #13	F000257	1. Resident #14 was affected by this alleged deficient practice because she feels the room is too hot. Her roommate has agreed to keep the shade, in the shared room, closed during the day when the sun is out. Both residents have agreed to open the window, as needed, to keep the room temperature anywhere from 71 to 81 degrees. 2. No other residents have been affected by this alleged deficient practice. 3. During the season when the weather is in transition, both roommates have agreed to have the shade pulled during the time the sun is out. They have both	11/20/2014

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	was observed resting in her bed with a thin night gown on and a sheet pulled across her legs, a fan was observed at the foot of her bed and it was running on the low speed. On 10/22/14 from 10:30 A.M. to 10:50 A.M., an environmental tour was conducted with the Administrator and the Maintenance Supervisor, during which the following was observed: East hallway: At 10:45 A.M., Resident #13 was observed resting in her bed with a thin nightgown on and a fan running at the foot of her bed. The Maintenance Supervisor checked the air temperature with his thermometer and the room temperature was 82.3 degrees Fahrenheit at the resident's bedside. The Maintenance Supervisor walked across the room to the window and checked the air temperature beside the window and the reading was 85.6 degrees Fahrenheit. The Maintenance Supervisor confirmed that the electric base board heat in the room was not even on. During an interview on 10/22/14 at 10:50 A.M., the Administrator indicated Resident #13's roommate liked the room warmer and refused to have the light		agreed if the temperature rises to above 81 degrees that the window can be slightly opened to lower the room temperature between 71-81 degrees. Both residents have been offered the opportunity to move rooms; however, both have declined. The room temperature in Resident #14's room will be checked twice daily, during seasonal transition (See Exhibit 11). This will ensure the room temperature is maintained between 71-81 degrees. During the winter months, if the temperatures are remaining stable, temperatures will be taken randomly 3x per week. This will be determined by the QA committee. Maintenance will complete room temperatures during the weekdays and nursing will complete room temperatures on the weekends. Nursing and Maintenance will be in-serviced on 11-12-14 through 11-14-14. 4. Weekly the Supervisor of Maintenance will present any issues with the temperature findings at the Weekly QA meeting (See Exhibit 10). The Weekly QA Committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2 - Unit Managers, Staff Development Coordinator, Social Service Director, Business Office Manager, Medical Records, Dietary Director, Activity Director and Environmental Services Director. The Medical	

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	filtering blinds pulled. The Administrator further indicated the morning sun shined in the window and created a lot of heat. It would have helped if the roommate would of agreed to close the blinds, but she refused. 3.1-19(h)		Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to careplan assistive devices used by the resident for	F000279	1. Resident #64 was not affected by this alleged deficient practice. The individual care plan for this resident was updated on	11/20/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mobility and to aid in the prevention of a fall/accident in 1 of 3 resident's reviewed for accidents. (Resident #64) Finding includes: The clinical record of Resident #64 was reviewed on 10-20-14 at 9:15 A.M. The resident's diagnoses included but were not limited to: dementia, depression, hypertension, and hypertonicity of the bladder. On 10-20-14 at 9:20 A.M., a review of the Fall Incident Report indicated Resident #64 fell, on 9-26-14 around 8:45 A.M., while walking to the bathroom with bare feet. The report indicated the new interventions implement were "... Education was done on importance of using her walker and using a call light for help if needed...." There were no apparent injuries. The fall incident report was reviewed the same day by the FAIR (Fall/Accident Disciplinary Review) Committee with further recommendations to prevent a fall which included: further education with the resident about the importance of wearing non-skid socks or shoes to prevent resident from slipping. The resident was instructed to call for help if she felt the floor appeared wet or cluttered and to use the call light if her		10-21-14. The intervention added reads "know that Resident #64 is up independently and prefers to use wheelchair when out of room and walker when in her room". This information is available for staff on the CNA care plan posted behind the head of the bed. (See Exhibit 12) 2. All residents who require or choose to use an assistive device have the potential to be affected by this alleged deficient practice. All residents will have their individual care plans reviewed to ensure their means of mobility and any assistive devices are included. This information will be available for staff on the CNA care plan posted behind the head of the bed. All will be reviewed by 11-17-14. 3. All new admissions will have a Fall Risk Assessment completed within 24 hours of admission. This also will include determining the resident's mobility, and the use of any assistive devices. The mobility and assistive devices will automatically write to the individual residents Fall Care Plan. The individual care plan information is available for staff on the CNA care plan posted at the head of the bed. The Unit Manager will continue to place the CNA care plans at the head of the bed. Any subsequent Fall Risk Assessments completed; annual, quarterly, change of condition, etc., will include reviewing the mobility and assistive devices	

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	155073	A. BUILDING 00 B. WING	10/22/2014

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	shoes weren't within reach. The resident was then given an opportunity to give additional suggestions and the resident stated she would make sure she had her shoes on. The report further indicated "...Did not change care plan...." A review of the last quarterly fall assessment, dated 9-8-14, indicated the resident was at a high risk for a fall and had a balance problem while walking. The fall assessment further indicated the resident required use of an assistive device (cane, wheelchair, walker) but didn't specify which one. On 10-20-14 at 9:35 A.M., a careplan, dated 4-12-13 and revised on 9-8-14, indicated the resident was at risk for falls related to dementia. The interventions included: skid-proof footwear, pathway clear, call light within reach, remind resident to ask for assistance if needed, monitor gait and posture, do fall risk assessment per facility protocol, and assess need for safety devices. On 10-20-14 at 9:45 A.M., the resident was observed propelling herself from the activity room in a wheelchair. On 10-20-14 at 10:15 A.M., the Quarterly MDS (Minimum Data Set) Assessment, dated 9-5-14, indicated the resident used		used, if any. The care plan will be reviewed at that time to ensure it is accurate. The "Fall Risk Assessment" policy has been reviewed and updated to include these changes (See Exhibit 13). All nurses will be in-serviced on the "Fall Risk Assessment" policy on 11-12-14 through 11-14-14. 4. The Unit Managers will report weekly in the Weekly QA (See Exhibit 10) Committee meeting of any mobility, assistive devices and care plan discrepencies noted for the Fall Risk Assessments reviewed that week. The weekly QA Committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2 - Unit Managers, Staff Development Coordinator, Social Service Director, Business Office Manager, Medical Records, Dietary Director, Activity Director and Environmental Services Director. The Medical Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	

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	mobility devices such as a wheelchair and walker. The assessment further indicated the resident walked in her room independently and required no staff help or oversight. During an interview, on 10-20-14 at 10:25 A.M., CNA #11 indicated she was not sure what the resident's interventions were to prevent falls from occurring. However, she indicated a CNA Assignment Card/Careplan was located at the head of the bed and the interventions would be included on the form. During an interview, on 10-20-14 at 10:28 A.M., Unit Manager #12 indicated the the resident uses a wheelchair outside of her room and a walker to transfer in her room. She further indicated the resident transferred herself and decided which assistive device she would use. On 10-20-14 at 3:00 P.M., a review of the CNA Assignment Card, located a the head of bed for Resident #64 indicated the following: use skid-proof footwear, keep pathways clear, call light within reach and remind resident to ask for assistance if needed. The CNA Assignment Card did not indicate the resident was to use a walker when ambulating in her room or a wheelchair when ambulating in the hallways. A			

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	walker was observed to be located near the resident as she was sitting in a recliner. During an interview, on 10-21-14 at 1:20 P.M., the DON indicated all interventions to prevent a fall should have been on the careplan, including assistive devices. The DON further indicated the CNA Assignment Card would also have been updated to include interventions such as assistive devices. The DON could not explain why Resident # 64's careplan nor CNA Assignment Card did not include the use of a walker or wheelchair with ambulation to prevent falls. 3.1-35(a)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.			

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	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interview, the facility failed to ensure the care plan related to activities for 1 of 3 residents reviewed for activities was updated to reflect her current status. (Resident #67) Finding includes: Resident #67 was observed, on 10/16/17 from 8:30 A.M. - 12:00 P.M. and 1:00 P.M. - 3:00 P.M., to be sleeping in her bed. She was not observed to participate in any scheduled activities. Resident #67 was observed, on 10/17/14 from 9:00 A.M. - 11:00 A.M., lying in her bed asleep. Resident #67 was observed, on 10/17/2014 at 2:39 P.M., lying in her bed asleep. There were several residents observed in the dining room, across from	F000280	1. Resident #67's care plan has been updated to reflect her current status (See Exhibit 14). 2. All residents have the potential to be affected by this alleged deficient practice. A report has been made for each resident that will pull the care plan, activity interests and activity assessments (See Exhibit 15). The information in the report will be reviewed and the care plans will be updated, if needed, to reflect the resident's current status. The care plans and activity interests will be completed, if needed, by 11-18-14. 3. Each week a report in ECS will be ran that identifies each resident's activity interest and if the resident did not attend the activity that reflects their interests, it will flag on the report (See Exhibit 8). Activities will then evaluate each flagged resident to monitor if the care plan needs to be changed and make adjustments as needed. A policy/procedure has been	11/20/2014

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	the resident's room, playing Bingo. Resident #67 was observed, on 10/20/14 at 9:00 A.M., lying in her bed asleep. Resident #67 was observed, on 10/20/2014 at 10:42 A.M., propelling herself around the facility and eating a donut. The beautician indicated she had cut and dried resident's hair earlier in the morning. Resident #67 was observed, on 10/20/2014 at 11:00 A.M., propelling herself around the front hall of the facility. She was noted to go into the doorway to the front lounge where exercises was being conducted and she asked "who are they watching?" She did not enter the room or participate in activities, but watched the activity for a few minutes from the entryway. Resident #67 was observed on, 10/20/2014 2:00:18 P.M., propelling her wheelchair around the facility. There had been a previously scheduled activity of "Fancy Nails" conducted in the activity room. The resident's fingernails were not noted to have been manicured or painted. Resident #67 was observed, on 10/20/2014 3:08 P.M., propelling her		developed "Activity Audits/Assessments/Care Plans" (See Exhibit 9), that describes the weekly audits and how they are to be reviewed. An in-service will be held for all Activity Staff on 11-15-14 through 11-18-14. 4. The Activity Director will report any residents who have needed to have a care plan/interests updated to reflect their current status, due to the weekly audits. (See Exhibit 10). The weekly QA committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2-Unit Managers, Staff Development Coordinator, Social Services Director, Business Office Manager, Medical Records, Activity Director, Dietary Manager and Environmental Services Director. The Medical Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	

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	wheelchair around the facility holding a big stuffed frog. The resident was smiling and enjoyed talking briefly about her frog though she did not stop propelling her wheelchair to talk. Resident #67 was observed, on 10/21/2014 9:54 A.M., in her bed asleep. Her roommate indicated she had slept a lot this morning. Staff were heard inviting a few residents to a 10:00 Yahtzee activity. The clinical record for Resident #67 was reviewed on 10/20/14 at 10:10 A.M. The record indicated the resident was admitted on 12/16/14 The resident's diagnoses included, but were not limited to: dementia, hypertension, and depression. An initial activity assessment for Resident #67, completed on 12/23/13, indicated the resident enjoyed visiting with family and friends, was a member of the Catholic church, liked to listen to quiet music and instrumental music, liked to watch television and movies, liked to keep up on the news, enjoyed social events and parties, liked watching birds and other animals, liked to be outside, would like to be asked to go on outings, and liked to do crossword puzzles, puzzles, trivia word games and play			

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	Bingo. Activity notes, dated 01/14/14, indicated an MDS (Minimum data set) assessment was done due to overall improvement in ADL (activities of daily living) improvements. The note indicated the resident was cheerful and enjoyed visiting with people, had frequent family visits, liked birds and animals, liked to listen to quiet music, occasionally attended exercises and Bingo, read magazines and newspapers, watching the television and news programs, liked to garden and be outside, liked to go on outings, liked crossword puzzles, puzzles, trivia word games, and was a member of a Catholic church. A quarterly activity note, dated 04/03/14, indicated the resident came to an activity only occasionally, like to wheel herself around the facility and look at things, liked to sleep a lot, was not very talkative, could carry on small conversations with others, liked to look out the windows in the dining room and was visited regularly by her children. Another quarterly activity note, dated 10/01/14, indicated the resident was visited frequently by her daughter, slept through the day but if she was up enjoyed wheeling herself around the facility, was confused and sometimes argumentative,			

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	would sometimes join exercises, and would passively observed activities at times, and liked to sit by the window and look outside. An activity attendance record, from 10/13/14 - 10/20/14, indicated the resident had gone to the beauty shop one time, had participated in drink cart 5 times, had participated in a pre-meal soup one time, and had participated in a popcorn event one time in the past week. The care plan for Resident #67, initiated on 12/23/13 and current through 01/15/15, regarding activities, indicated the resident needed encouragement to attend activities. The interventions included to provide/review the activity calendar, assist to activities, inform of activities, praise involvement, and invite and encourage daily. The goal was for the resident to be involved in group activities, group outings, and out of room activity daily, 2 - 3 times a week. An interview with the Activity Director, on 10/22/14 at 9:00 A.M., indicated the resident's activity involvement had declined. The Activity Director confirmed the resident really did not join group activities anymore. She indicated if the resident was awake, she would wheel herself around the facility in her			

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	wheelchair and might occasionally observe brief parts of an activity passively. She indicated the drink cart and pre-meal soup activity consisted of the activity assistant serving soup and beverages before the meal and passing beverages in the afternoons. The Activity Director indicated the resident's daughter, whom visited her frequently, was aware of the resident's decline in activity attendance and participation. There was no revised plan to address activities to meet the resident's current needs. 3.1-35(d)(2)(B)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure assistive devices were careplanned and implemented to prevent a fall for 1 of 3 residents reviewed for accidents. (Resident #64)	F000323	1. Resident #64 was not affected by this alleged deficient practice. The individual care plan for this resident was updated on 10-21-14. The intervention added reads "know that Resident #64 is up independently and prefers to use wheelchair when out of room	11/20/2014

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	Finding includes: The clinical record of Resident #64 was reviewed on 10-20-14 at 9:15 A.M. The resident's diagnoses included but were not limited to: dementia, depression, hypertension, and hypertonicity of the bladder. On 10-20-14 at 9:20 A.M., a review of a fall incident report indicated Resident #64 fell, on 9-26-14 around 8:45 A.M., while walking to the bathroom with bare feet. The report indicated the fall was unwitnessed by a staff member and the resident reported she slipped on some water. The resident was educated on the importance of using her walker and using a call light for help if needed. There were no apparent injuries. The fall incident report was reviewed the same day, by a FAIR (Fall/Accident Interdisciplinary Review) Committee, with further recommendations to prevent a fall which included: further education with the resident about the importance of wearing non-skid socks or shoes to prevent resident from slipping. The resident was also instructed to call for help if she felt the floor appeared wet or cluttered and to use the call light if her shoes weren't within reach. The resident was then given an opportunity to give		and walker when in her room". This information is available for staff on the CNA care plan posted behind the head of the bed. (See Exhibit 12) 2. All residents who require or choose to use an assistive device have the potential to be affected by this alleged deficient practice. All residents will have their individual care plans reviewed to ensure their means of mobility and any assistive devices are included. This information will be available for staff on the CNA care plan posted behind the head of the bed. All will be reviewed by 11-17-14. 3. All new admissions will have a Fall Risk Assessment completed withinn 24 hours of admission. This also will include determining the resident's mobility, and the use of any assistive devices. The mobility and assistive devices will automatically write to the individual residents Fall Care Plan. The individual care plan information is available for staff on the CNA care plan posted at the head of the bed. The Unit Manager's will continue to place the CNA care plans at the head of the bed. Any subsequent Fall Risk Assessments completed; annual, quarterly, change of condition, etc., will include reviewing the mobility and assistive devices used, if any. The care plan will be reviewed at that time to ensure it is accurate. The "Fall Risk Assessment"	

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	additional suggestions and the resident indicated she would make sure she had her shoes on. The FAIR Report further indicated the careplan was not changed. A review of the last quarterly fall assessment, dated 9-8-14, indicated the resident was at a high risk for a fall and had a balance problem while walking. The fall assessment further indicated the resident required use of an assistive device (cane, wheelchair, walker) but didn't specify which one. On 10-20-14 at 9:35 A.M., a careplan, dated 4-12-13 and revised on 9-8-14, indicated the resident was at risk for falls related to dementia. The interventions included: skid-proof footwear, pathway clear, call light within reach, remind resident to ask for assistance if needed, monitor gait and posture, do fall risk assessment per facility protocol, and assess need for safety devices. On 10-20-14 at 10:15 A.M., the Quarterly MDS (Minimum Data Set) Assessment, dated 9-5-14, indicated the resident used mobility devices such as a wheelchair and walker. The assessment further indicated the resident walked in her room independently and required no staff help or oversight. The resident's BIMS (Brief Interview Mental Status) score was 15,		policy has been reviewed and updated to include these changes (See Exhibit 13). All nurses will be in-serviced on the "Fall Risk Assessment" policy on 11-12-14 through 11-14-14. 4. The Unit Managers will report weekly in the Weekly QA (See Exhibit 10) Committee meeting of any mobility, assistive devices and care plan descrepencies noted for the Fall Risk Assessments reviewed that week. The weekly QA Committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2 - Unit Managers, Staff Development Coordinator, Social Service Director, Business Office Manager, Medical Records, Dietary Director, Activity Director and Environmental Services Director. The Medical Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	

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	which indicated her cognition was intact. During an interview, on 10-20-14 at 10:25 A.M., CNA #11 indicated she was not sure what the resident's interventions were to prevent falls from occurring. However, she indicated a CNA Assignment Card/Careplan was located at the head of the bed and the interventions would be included on the form. During an interview, on 10-20-14 at 10:28 A.M., Unit Manager #12 indicated the resident used a wheelchair outside of her room and a walker to transfer/ambulate in her room. She further indicated the resident transferred herself and decided which assistive device she would use. On 10-20-14 at 3:00 P.M., a review of the CNA Assignment Card located a the head of bed for Resident #64 indicated the following: use skid-proof footwear, keep pathways clear, call light within reach and remind resident to ask for assistance if needed. The CNA Assignment Card did not indicate the resident was to use a walker when ambulating in her room or a wheelchair when ambulating in the hallways. During an interview, on 10-21-14 at 1:20 P.M., the DON (Director of Nursing)			

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	indicated all interventions to prevent a fall should have been added to the careplan, including assistive devices. The DON further indicated the CNA Assignment Card would also have been updated to include interventions such as assistive devices. The DON could not explain why Resident # 64's careplan nor CNA Assignment Card did not include the use of a walker or wheelchair with ambulation prior to the fall. 3.1-45(a)(2)			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under			

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	155073	A. BUILDING 00 B. WING	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

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	proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure there was an accurate system for liquid narcotic reconciliation. This deficient practice affected 2 of 2 halls in the facility. Finding includes: During the observation of the medication carts for both the East and West nursing units, conducted on 10/20/2014 between 2:19 - 3:15 P.M., the following was noted: On Medication cart #1, a cart for the West unit, the liquid narcotic pain medication for Resident #74 observed in a vial appeared to have what looked like 28 ml's (milliliters) of medications. The liquid was noted to be between the 24 and 30 ml hashmarks but was closer to	F000431	1. Residents #13, 39, 47 and 78 were not affected by this alleged deficient practice. The medicine bottles have been changed to reflect the correct dosage. 2. All residents who have a physician's order for a liquid narcotic have the potential to be affected by this alleged deficient practice. There are no other residents with these orders except those identified in #1. 3. William Herman, RPH, Controlled Substance Compliance Officer with Omnicare Pharmacy in South Bend, Indiana, acknowledges that the stock bottles from the manufacturer are over filled. He has completed in-service training with his staff on this matter. The education included instructing them to fill individual dispensing containers to exactly 30 ml. The bottle for future use in Pilgrim Manor will contain 30 ml, avoiding overfill/count issues. Kori Hauersperger, RPH, Pharm DH, Consultant Pharmacist from	11/20/2014

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	the 30 ml hash mark. LPN #3 indicated it looked like about 28. The Narcotic record sheet indicated there should have only been 25.75 ml of medication left in the container. On Medication cart #3, on the East unit, the liquid narcotic pain medication for Resident #13 contained just barely under the 4 ml hash mark. The narcotic record sheet indicated there should have only been 2 ml's left in the bottle. There was also an unopened bottle of the same liquid narcotic medication, Roxanol, for Resident #13 which contained over 30 ml's of medication. However, the coordinating narcotic record sheet indicated there was only 30 ml's dispensed in the bottle. On Medication cart #4, RN #4 and RN #5 were noted to be in the middle of the daily narcotic medication count process. RN #4, who was reading the narcotic count sheet amounts to RN #5, who was observing the medications, indicated the liquid narcotic Roxanol medication for Resident #39 was to have 11 ml of medication. However, RN #5 indicated there was just under 16 ml's of the medication in the bottle. RN #4 indicated the Roxanol bottles were overfilled but the narcotic record sheet amounts and the visualized amounts were		Omnicare for our facility was consulted on this matter. She has instructed us to inspect each new liquid controlled substance bottle dispensed to ensure it contains only the amount on the label before accepting it from the pharmacy. Pilgrim Manor will refuse to accept any liquid narcotic bottle delivered to us that upon visual inspection contains an overfill. A new policy "Accepting Delivery of Liquid Controlled Substance" has been developed. This policy includes the procedure to follow for inspection of each new bottle to ensure it contains only the amount on the label before accepting it, and the steps to follow for refusing a bottle (See Exhibit 16). The "Controlled Substances; End of Shift Count" policy has been revised to include the procedure for measuring liquid controlled substances both unopened and opened bottles in regards to the dropper to obtain more accurate readings (See Exhibit 17). Also added to the policy is that there will be internal notification to all nurse managers when there has been a count correction completed. This notification will include date and time, the concern, who was notified and the date and time of the notification. All nurses will be in-serviced on 11-12-14 through 11-14-14 on the "Accepting Delivery of Liquid Controlled Substance" and "Controlled	

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	more accurate as the bottle was emptied. There was no other process or explanation given to the discrepancy or the facility's policy regarding the inaccurate Roxanol narcotic reconciliation amounts. In addition, the liquid narcotic medication, Roxanol bottle for Resident #78 was observed to contain over 30 ml's of medication. However, the narcotic reconciliation form indicated it should only have contained 28.75 ml's of medication. On 10/22/14 at 10:30 A.M., a review of the facility policy and procedure, titled "Controlled Substances; End of shift Count, dated 06/19/13, indicated the oncoming nurse or QMA was responsible to visualize the medication amounts and the off going nurse or QMA was to confirm the amount that is listed as the amount remaining on each of the individual count sheets. The policy indicated if there was a discrepancy between the visualized amounts and the narcotic count record, a third nurse or QMA was to verify the discrepancy and then a "count corrected" documentation was to be added on the narcotic count record and signed by all three staff members. The nurse manager was to be immediately notified of the discrepancy and a detailed explanation given.		Substances; End of Shift Count" policies. 4. The appropriate Unit Manager will be given any pharmacy manifest delivery slips, that were from a liquid controlled substance, refused delivery that was the result of an overfill. All count corrections shall be reported to an in-house nurse manager or the "on call" nurse manager. In addition there will be an internal notification to all nurse managers of such. The Unit Managers will report weekly to the weekly QA (See Exhibit 10) Committee meeting of any liquid controlled substance refusals from the pharmacy. The Nurse Managers (Director of Nursing, East and West Unit Managers, MDS Coordinator and Staff Development Coordinator) will report weekly to the weekly QA (See Exhibit 10) of any count corrections. The weekly QA Committee is represented by: Administrator, Director of Nursing (DON), Unit Managers, MDS Coordinator, Staff Development Coordinator, Medical Records, Activity Director, Business Office Manager, Social Service Director, Environmental Service Director and Dietary Manager. The Medical Director will receive copies of the Weekly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.	

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	During an interview, on 10/22/14 at 11:00 A.M., the Staff Development nurse, LPN #6, indicated she was aware the Roxanol sometimes seemed to be "overfilled" when delivered from the pharmacy but there was no policy in place that she was aware of, to account for the overage to ensure the narcotic count sheet policy could be followed to ensure accuracy. 3.1-25(e)(2)			