STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155458	A. BUILDING 00 B. WING	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 30 and 31, August 1, 2, and 3, 2018. Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 25 Total: 25 Census payor type: Medicare: 3 Medicaid: 15 Other: 7 Total: 25 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/8/18.	F 0000		
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State			

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

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	Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is			

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	transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual			

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	who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure the Long Term Care Ombudsman was notified of resident transfers to the hospital as well as notifying the resident and the resident's representative in writing of the reason for the transfer for 2 of 2 residents reviewed for hospitalization. (Residents 26 and 5) Findings include: 1. The closed record for Resident 26 was reviewed on 8/2/18 at 12:59 p.m. Diagnoses included, but were not limited to, presence of functional implant, accidental discharge of firearm, osteomyelitis, fracture of shaft of right tibia and fibula, major depressive disorder, bipolar, and acute pain due to trauma. A nursing note, dated 6/14/18, indicated the resident was transferred to the hospital for a psychiatric evaluation and treatment. There was no documentation to indicate the State required transfer and discharge form was completed and/or provided to the resident and/or his representative. There was also no documentation to indicate the Ombudsman was notified of the transfer to the hospital. Interview with the Social Service Designee on 8/3/18 at 9:30 a.m., indicated the Ombudsman was	F 0623	**Corrective actions for residents affected** Resident # 26 no longer resides in the facility Resident # 5 is a current resident and was not affected by the deficient practice **How other residents will continue to be identified** All residents have the potential to be affected by the deficient practices. **System Revision:** In-service was completed 8/1/18 with all clinical staff and SSD with explanation of Discharge process and paperwork required Discharge/Transfer packets were completed inclusive of the Resident Transfer/Discharge forms. The SSD/Designee will audit discharged residents discharge paperwork weekly for 4 weeks beginning the week of 8/13/18 to ensure completion of forms providing reeducation to staff **How the facility will monitor**	09/02/2018

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	not notified of the resident's transfer to the hospital. She only notified the Ombudsman when residents were discharged home. Interview with the Minimum Data Set (MDS) Coordinator on 8/3/18 at 10:15 a.m., indicated a transfer and discharge form was not completed at the time of discharge. 2. The record for Resident 5 was reviewed on 7/31/18 at 1:57 p.m. Diagnoses included, but were not limited to, hemiplegia, dementia, hypertension, atrial fibrillation, depression, and schizophrenia. The SBAR (Situation, Background, Assessment, Recommendation) form, dated 4/11/18 at 5:51 p.m., indicated the resident had a change in condition and Physician orders were received to send the resident to the hospital. A nursing note dated 4/11/18 at 11:08 p.m., indicated the resident was admitted to the hospital with a diagnosis of altered mental status. There was no documentation to indicate the State required transfer and discharge form was completed and/or provided to the resident and/or his representative. There was also no documentation to indicate the Ombudsman was notified of the resident's transfer to the hospital. Interview with the Director of Nursing on 7/31/18 at 2:21 p.m., indicated a transfer and discharge form was not completed at the time of discharge. Interview with the Social Service Designee on 8/3/18 at 9:30 a.m., indicated the Ombudsman was not notified of the resident's transfer to the hospital. She only notified the Ombudsman when residents were discharged home.		**the system:** The SSD/Designee will; thereafter, audit discharged residents discharge paperwork monthly for 6 months to ensure completion of forms providing reeducation to staff as necessary. QAPI Committee will review monthly to ensure compliance has been achieved Completion Date: 9/2/18	

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	3.1-12(a)(6)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure the bed hold policy was issued at the time of transfer for 2 of 2 residents reviewed for hospitalization. (Residents 26 and 5) Findings include:	F 0625	Corrective actions for residents affected: Resident # 26 has been discharged from the facility Resident # 5 is a current resident and was not affected by the	09/02/2018

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	1. The closed record for Resident 26 was reviewed on 8/2/18 at 12:59 p.m. Diagnoses included, but were not limited to, presence of functional implant, accidental discharge of firearm, osteomyelitis, fracture of shaft of right tibia and fibula, major depressive disorder, bipolar, and acute pain due to trauma. A nursing note, dated 6/14/18, indicated the resident was transferred to the hospital for a psychiatric evaluation and treatment. There was no documentation to indicate the State form related to bed hold and appeal rights was not given to the resident or responsible party at the time of the transfer. Interview with the Minimum Data Set (MDS) Coordinator on 8/3/18 at 10:15 a.m., indicated the bed hold policy had not been given to the resident or responsible party at the time of the transfer. 2. The record for Resident 5 was reviewed on 7/31/18 at 1:57 p.m. Diagnoses included, but were not limited to, hemiplegia, dementia, hypertension, atrial fibrillation, depression, and schizophrenia. The SBAR (Situation, Background, Assessment, Recommendation) form, dated 4/11/18 at 5:51 p.m., indicated the resident had a change in condition. Physician orders were received to send the resident to the hospital. A nursing note dated 4/11/18 at 11:08 p.m., indicated the resident was admitted to the hospital with a diagnosis of altered mental status. There was no documentation to indicate the State form related to bed hold and appeal rights was		deficient practice How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice System Revision: In-service were started on 8/1/18 and completed on 8/20/18 with all clinical staff and SSD by the DON notifying that the facility must include a copy of our bed hold policy to the resident or representative at the time of transfer Discharge/Transfer packets were completed inclusive of the Bed Hold Policy SSD/DON will audit transferred residents paperwork weekly for 4 weeks beginning the week of 8/13/18 How the facility will monitor the system: The SSD/DON will audit transferred residents discharge paperwork monthly for 6 months to ensure completion of forms and providing reeducation to staff as necessary. QAPI Committee will review monthly to ensure compliance has been achieved Completion Date 9/2/18	

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	given to the resident or responsible party at the time of the transfer. Interview with the Director of Nursing on 7/31/18 at 2:21 p.m., indicated the bed hold policy had not been given to the resident or responsible party at the time of the transfer. 3.1-12(a)(25)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been			

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	made for the resident's follow up care and any post-discharge medical and non-medical services. Based on record review and interview, the facility failed to ensure a discharge summary had been completed for 1 of 1 residents reviewed for discharge to the community. (Resident 27) Finding includes: The closed record for Resident 27 was reviewed on 7/31/18 at 3:26 p.m. Diagnoses included, but were not limited to, cellulitis of left and right lower limb, non pressure chronic ulcer of left and right foot, diabetes, peripheral vascular disease, hypertension, rheumatoid arthritis, anemia, and mixed anxiety disorder. The resident was discharged home on 5/14/18. A post discharge plan of care was signed by the resident on 5/14/18, however, there was no discharge summary completed which included a recapitulation of the resident's stay. Interview with the Director of Nursing on 8/3/18 at 10:15 a.m., indicated the facility had not been completing discharge summaries of the residents' stays. 3.1-36(a)(1)	F 0661	Corrective actions for residents affected: Resident # 27 no longer resides in the facility How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice System Revision: Facility designated DON/MDS Coordinator to complete the discharge summary for each resident that has been discharged from the facility In-service was completed 8/20/18 will all clinical staff and SSD by DON informing that the Discharge Summary must be completed with each discharge The DON/MDS will audit discharged paperwork weekly for 4 weeks to ensure completion of the discharge summary in a timely manner How the facility will monitor the system: A QA tool has been developed to ensure discharge summaries are being completed as required The DON or Designee will thereafter, audit transferred residents discharge paperwork monthly for 6 months to ensure	09/02/2018

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			completion of discharge summary QAPI Committee will review monthly to ensure compliance has been achieved Completion Date: 9/2/18	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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; Based on observation, record review, and interview, the facility failed to ensure nail care was provided for dependent residents for 1 of 3 residents reviewed for activities of daily living. (Resident 10) Finding includes: On 7/30/18 at 9:43 a.m., Resident 10 was observed with long fingernails on her left hand with a brown substance underneath her nails. On 8/1/18 at 10:20 a.m., and on 8/2/18 at 8:30 a.m., the resident's fingernails remained long with a dark substance underneath her nails. On 8/3/18 at 9:05 a.m., the resident's fingernails remained long on the left hand with a dark substance underneath. The record for Resident 10 was reviewed on 7/31/18 at 11:31 a.m. Diagnoses included, but were not limited to, Parkinson's disease, heart failure, hypertension, major depressive disorder, abnormal posture, anxiety disorder, osteoporosis,	F 0677	Corrective actions for residents affected: Fingernails for resident # 10 were cleaned and trimmed. Care plan updated for hand hygiene daily and as needed. How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice System Revision: In-service was completed on 8/20/18 by DON with all clinical staff providing education that all residents must have their nails assessed after meal times in addition to thorough care during showers The facility will assess and monitor for the completion of all resident's ADL care. The DON or Designee will conduct	09/02/2018

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	insomnia, and disorganized schizophrenia. The Annual Minimum Data Set (MDS) assessment, dated 5/23/18, indicated the resident was alert and oriented for decision making and needed extensive assistance with personal hygiene. The current plan of care, indicated the resident had an ADL (activities of daily living) self performance deficit related to dementia, Parkinson's, limited mobility and contractures. Interventions included, but were not limited to, provide extensive to total assist with grooming and bathing. Shower orders, dated 3/27/18, indicated the resident was to receive a shower twice weekly and as needed every evening shift on Tuesday and Friday. The July 2018 Treatment Administration Record (TAR) indicated the resident had received a shower on 7/31/18. Interview with the Director of Nursing on 8/3/18 at 10:15 a.m., indicated the resident can be resistive to care at times and she would see if she could clean the resident's fingernails. 3.1-38(a)(3)(E)		daily spot checks based on resident's shower schedules to ensure that proper ADL care has been rendered How the facility will monitor the system: The DON/Designee will audit resident's ADL's and hand hygiene weekly for 4 weeks The DON/Designee will thereafter audit residents ADL's and hand hygiene monthly for 6 months QAPI Committee will review monthly to ensure compliance has been achieved and maintained Completion Date: 9/2/18	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall prevention measures were implemented for 2 of 2 residents reviewed for falls. (Residents 10 and 6) Findings include: 1. On 7/31/18 at 1:22 p.m., Resident 10 was observed in bed sleeping. The resident's wheelchair was at the foot of the resident's bed. There was no dycem (a piece of material to prevent sliding) on top of the resident's wheelchair cushion or underneath the cushion. On 8/1/18 at 1:45 p.m., the resident was in her room in bed. There was no dycem on top of the resident's wheelchair cushion or underneath the cushion. The record for Resident 10 was reviewed on 7/31/18 at 11:31 a.m. Diagnoses included, but were not limited to, Parkinson's disease, heart failure, hypertension, major depressive disorder, abnormal posture, anxiety disorder, osteoporosis, insomnia, and disorganized schizophrenia. A nursing progress note, dated 7/19/18 at 3:00 p.m., indicated the resident rolled out of bed and received a laceration above her left eyebrow and bruising to the bridge of her nose. The resident was sent to the emergency room for evaluation and returned with 3 sutures above the left eyebrow. The plan of care, dated 4/4/18, indicated the resident was at risk for significant injury from falls	F 0689	Corrective actions for residents affected: Residents #6 and # 10 were reassessed for non-skid pad to wheelchair to prevent sliding. Non-skid pads were placed in the wheelchair How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice System Revision: Dycem Pad was discontinued and Non-skid pad was ordered Resident care plans were updated to state that non-skid pads would be used All residents requiring specific fall preventions were assessed and all appropriate interventions were completed In-service completed 8/16/18 by DON educating staff to review care cards at the start of each shift to ensure proper interventions are in place with each rounding/transfer of resident The DON/MDS Coordinator will evaluate residents care plans/cards weekly for 4 weeks beginning 8/13/18 and update interventions as needed Following that weekly review, the	09/02/2018

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	due to Parkinson's, decreased mobility and contractures. Interventions included, but were not limited to, dycem to top of wheelchair pad and under the wheelchair cushion. Interview with the Minimum Data Set (MDS) Coordinator on 8/2/18 at 1:00 p.m., indicated the interventions on the resident's care plan had been updated, she also confirmed the dycem had not been in place. 2. On 7/31/18 at 10:01 a.m., Resident 6 was observed seated in her wheelchair in the dining room. Her right eyebrow was puffy and bright pink, she had two scabs noted to her right elbow, and fading discolorations to her right arm. There was no dycem (a non-slip material) noted to the top of the resident's wheelchair cushion. On 8/01/18 at 1:12 p.m., the resident was observed seated in her wheelchair in front of the nursing station, there was no dycem noted to her wheelchair cushion. The record for Resident 6 was reviewed on 8/01/18 at 2:04 p.m. Diagnoses included, but were not limited to, dementia and repeat falls. The Quarterly MDS (Minimum Data Set) assessment, dated 5/2/18, indicated the resident was confused with decision making and required an extensive 1 person physical assist with transfers. An incident report, dated 7/21/18, indicated the resident was found face down on the floor with a bloody laceration to her right eye brow. A care plan, dated 2/7/17, indicated the resident was at risk for significant injuries from falls due to decreased cognition and decreased safety awareness. The interventions included, but were		DON/MDS will audit residents to ensure all interventions are being followed How the facility will monitor the system: The DON/MDS will then update care cards as needed based on each resident, additionally the DON/MDS will audit residents to ensure all interventions are on the care cards are being followed monthly for 6 months QAPI Committee will review monthly to ensure compliance has been achieved Completion Date: 9/2/18	

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	155458	A. BUILDING 00 B. WING	08/03/2018

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	not limited to, dycem to wheelchair. The current CNA care card indicated the resident was to have a dycem to her wheelchair. Interview and observation with the Director of Nursing (DON) and CNA 1 on 8/1/18 at 1:32 p.m., indicated the resident did not have a dycem to her wheelchair. The DON was not aware of the resident's intervention. 3.1-45(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure a gradual dose reduction (GDR) was attempted for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 10) Finding includes: The record for Resident 10 was reviewed on 7/31/18 at 11:31 a.m. Diagnoses included, but were not limited to, Parkinson's disease, heart failure, hypertension, major depressive disorder, abnormal posture, anxiety disorder, osteoporosis, insomnia, and disorganized schizophrenia. A Physician's order, dated 3/27/18, indicated the	F 0758	Corrective actions for residents affected: Resident # 10 Psychiatrist was immediately contacted to obtain response via the GDR recommendation from pharmacy Reduction orders obtained and carried out per DON. Resident was not affected by the deficient practice How other residents will continue to be identified: All residents taking Psychotropic medications have the potential to be affected by the deficient practice	09/02/2018

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	resident was to receive Zyprexa (an antipsychotic medication) 5 milligrams (mg) daily for disorganized schizophrenia. A pharmacy recommendation, dated 5/11/18, indicated the resident had received Zyprexa 5 mg daily since June 2016 for schizophrenia. Please consider a GDR to 2.5 mg daily while monitoring for re-emergence of target and/or withdrawal symptoms. Documentation by the Physician indicated "Refer to Psych." The resident was seen by psychiatric services on 5/25/18. Documentation indicated Social Service had reported the resident's mood was stable and without verbal outbursts. Continue present medications. There was no documentation indicating if psychiatric services had been notified about the possible GDR. The resident was also seen by psychiatric services on 6/1/18 and 6/29/18. There was no documentation related to the pharmacy recommendation of the GDR. Interview with the Minimum Data Set (MDS) Coordinator on 8/3/18 at 11:35 a.m., indicated staff had been in contact with the Psych NP, the facility could attempt reducing the Zyprexa to 2.5 mg effective today. 3.1-48(b)(2)		System Revision: An audit was completed on all residents that receives psychotropic medications The care plans for this resident and all receiving Psychotropic medications has been updated All licensed nursing staff and Social Services Designee have been re-in serviced between 8/2/18 and 8/19/18 by the DON on Psychotropic Medication Policy and Procedures and following up with pharmacy recommendations All other residents with GDR on the date of the deficiency were reviewed for accuracy and completion How the facility will monitor the system: The DON/MDS Coordinator will audit GDR plans for each resident receiving psychotropic within 1 week of receiving recommendations by pharmacy for 4 weeks the randomly thereafter The DON/MDS will review the results of the monitoring completed under the Plan of Correction and findings will be presented to the QAPI Committee for further review and follow up Completion Date: 9/2/18	
F 0759 SS=D	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More			

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Bldg. 00	§483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, related to administering the wrong dose of medication, not monitoring a blood pressure before the administration of an antihypertensive medication, and not following the instructions after administration a nebulizer treatment for 2 of 5 residents observed during medication pass. Three errors were observed during 25 opportunities for errors during medication administration resulting in an error rate of 12.00%. (Residents 23 and 11) Findings include: 1. On 8/2/18 at 8:25 a.m., QMA 1 was observed preparing medications for Resident 23. She removed a medication punch card of Glyburide (a medication used to lower blood sugar) 5 milligrams (mg) and popped out 2 tablets into the med cup. The label on the medication card indicated Glyburide 5 mg give 10 mg twice a day. She removed another medication punch card of Doxazosin 2 mg and popped out 1 tablet into the cup. The label on the medication indicated to hold the medication if the systolic blood pressure was below 120. The QMA verified there were 11 pills total in the cup. QMA 1 walked to the dining room and identified Resident 23, she administered all the medications to the resident and left. The QMA did not take the resident's blood pressure before administering the medication. Interview with QMA 1 at 8:30 a.m., indicated she took the resident's blood pressure at 7:10 a.m., but	F 0759	Corrective actions for residents affected: Resident #23 was given the incorrect dosage of medication as alleged on CMS-2567 Resident was immediately checked for signs and symptoms of any adverse reactions Residents Physician was notified immediately regarding the error Resident #11 was noted not to rinse after receiving oral steroidal as alleged on the CMS-2567. DON assisted the resident to rinse after the findings were noted Resident # 23 and Resident # 11 were not affected by the deficient practice How other residents will continue to be identified: Any resident receiving medications have the potential to be affected by the same deficient practice System Revision: The licensed nurses and qualified medication assistant were in serviced between 8/2/18 and 8/19/18 by the DON on the facility policy on medication pass The DON/Designee will observe random medication pass with licensed nurses and qualified	09/02/2018

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	could not indicate what the blood pressure was, she said she wrote it down on a piece of paper but does not know what she did with it. The QMA indicated she takes all the blood pressures first then passes her medications. The record for Resident 23 was reviewed on 8/2/18 at 10:46 a.m. Physician orders, dated 7/1/18, indicated Cardura 2 mg (Doxazosin Mesylate) give 1 tablet by mouth one time a day related to high blood pressure. Hold if systolic blood pressure below 120. Physician orders, dated 6/25/18, indicated discontinue Glyburide 10 mg twice a day and start Glyburide 5 mg twice a day on 6/26/18. On 8/2/18 at 11:15 a.m., the medication cart was observed with QMA 1 and the Director of Nursing (DON). The QMA removed the medication punch card of the Glyburide, the label on the card indicated Glyburide 5 mg give 10 mg twice a day and the medication was delivered to the facility on 6/20/18. The QMA indicated she administered 2 pills of the Glyburide this morning to Resident 23. The DON reviewed the Medication Administration Record (MAR) and the order indicated the resident was to receive 5 mg, not 10 mg, twice a day. The QMA and DON reviewed the Physician orders and indicated the Glyburide 10 mg was discontinued on 6/26/18 and the label on the current medication punch card had not been changed to reflect the current order. Interview with the DON on 8/2/178 at 11:30 a.m., indicated the QMA should have taken the resident's blood pressure at the time she administered the medication.		medication assistant to ensure proper medication pass techniques AQA tool ahs been developed to address survey findings and to ensure findings will not recur in the future How the facility will monitor the system: The DON/Designee will conduct an audit using the audit tool 3 x's a week for 4 weeks then monthly for 6 months to ensure compliance is maintained The DON/Designee shall report the results of the audit to the QA team monthly to ensure 100% compliance is achieved and maintained Completion Date: 9/2/18	

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	2. On 8/2/18 at 8:55 a.m., LPN 1 was observed preparing medications for Resident 11. She removed a package from the box of Budesonide (Pulmicort a steroidal breathing treatment) 0.5 milligrams (mg)/2 milliliters (ml) for an aerosol nebulizer treatment. The label on the box indicated to rinse mouth out after use with water and spit. The LPN obtained vital signs, assessed the resident before and after the nebulizer breathing treatment, sanitized the equipment, and left the room after it had been completed. The LPN did not offer the resident any water to rinse his mouth out afterwards. Interview with LPN 1 on 8/2/18 at 9:15 a.m., indicated she did not offer or instruct the resident to rinse his mouth out after the nebulizer treatment. The record for Resident 11 was reviewed on 8/2/18 at 10:19 a.m. Physician orders, dated 6/2/18 indicate Pulmicort Suspension 0.5 mg/2 ml (Budesonide) 0.5 mg inhale orally two times a day. Interview with the Director of Nursing on 8/2/18 at 11:30 a.m., indicated the LPN should have instructed the resident to rinse his mouth out after the breathing treatment had been completed. 3.1-48(c)(1)			
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form			

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	designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure food was prepared in a form designed to meet individual needs related to not following the recipe for mechanically altered food for 2 of 2 observations. This had the potential to affect 2 of 2 residents who received mechanically altered food from the kitchen. Finding includes: On 8/2/18 at 10:15 a.m., Dietary Cook 1 was observed preparing pureed Swedish meatballs. The Cook indicated there were two residents who received pureed diets but she makes extra because they have good appetites. The Cook placed 12 meatballs in the food processor, she then used a slotted spoon and started adding cream of mushroom soup to the meatballs. The Cook indicated she added the soup until the mixture was the proper consistency. As she was blending the mixture, she used another spoon that was lying on the counter and used that to add more soup to the mixture. After the mixture was blended, she put it in a container to keep warm and washed the plastic food processor container and blade in the dishwasher. After cleaning the food processor, the Cook proceeded to prepare pureed stewed tomatoes. The Cook indicated she was using approximately 2 1/2 - 3 cups, she blended the tomatoes and indicated she was going to have to add thickener because the tomatoes were too soupy. The Cook opened the can of thickener and free poured the thickener into the tomato mixture. She did this again until the mixture was at the consistency she thought was appropriate. She did not measure the	F 0805	Corrective actions for the residents affected: The Dietary Manager has ensured that the pureed diets are at the correct consistency for the 2 residents identified as deficient at the next meal How other residents will continue to be identified: All residents on pureed diets are identified to have the potential to be affected by the same alleged deficiency System Revision: Administrator in serviced dietary manager on monitoring food preparation randomly All dietary cooks were in serviced by the dietary manager on 8/14/18 on preparing pureed foods per food preparation guidelines A QA tool was developed to monitor for accuracy How the facility will monitor the system: A QA audit will be completed by the administrator/designee 3 x's weekly for 4 weeks the monthly for residents on pureed diets to ensure the diet is prepared at the consistency indicated on the food preparation guidelines QA audits will be reviewed by QAPI committee monthly to assure compliance is achieved and maintained	09/02/2018

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	thickener nor did she follow a recipe for the Swedish meatballs or stewed tomatoes. The recipes for the Swedish meatballs and stewed tomatoes was provided by the Dietary Food Manager (DFM) on 8/2/18 at 2:03 p.m. The Swedish meatball recipe for 3 portions indicated 3 meatballs were to be used for each serving and 1/4 cup (4 Tablespoons) of water or stock was to be used. The stewed tomato recipe for 5 servings indicated five, 1/2 cup servings were to be used and 1/4 cup of food thickener was to be used. Interview with the DFM on 8/2/18 at 2:50 p.m., indicated the Cook should have followed the recipe for the pureed meatballs and tomatoes. 3.1-21(a)(3)		Completion Date: 9/2/18	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions related to dust on oven hoods, an accumulation of dust on electrical cords, cracked paint on the ceiling, and not sanitizing a thermometer while checking food temperatures in 1 of 1 kitchen areas. (The Main Kitchen) Findings include: 1. During the brief kitchen sanitation tour on 7/30/18 at 8:32 a.m., with Dietary Cook 2, the following was observed: a. There was cracked paint and plaster on the ceiling above the food prep station. b. The oven hood had an accumulation of dust. c. The black electrical cord located above the food prep station had an accumulation of dust. Interview with the Dietary Food Manager (DFM) on 8/2/18 at 2:50 p.m., indicated the above areas were in need of cleaning and/or repair. 2. On 8/2/18 at 11:20 a.m., Dietary Cook 1 was observed checking food temperatures prior to serving lunch. The Dietary Cook placed the thermometer in the meat. The Dietary Cook did not sanitize the thermometer prior to placing it in the meat. After removing the thermometer from the meat, the Dietary Cook wiped the thermometer off with a rag and placed the thermometer in the vegetables. After checking the temperature, the	F 0812	Corrective actions: Upon findings, the facility repaired the cracked paint and plaster on the ceiling above the food prep station immediately. The oven hood was cleaned by maintenance and scheduled for Bi annual cleaning on 8/21/18 Dust was cleaned fro the black electrical cord by maintenance Food thermometer was sanitized once identified How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice System Revision: Administrator in-serviced dietary manager on kitchen sanitation on 8/14/18 Dietary manager in serviced all cooks on sanitation and re sanitation 8/14/18 on the food thermometer Dietary manager re educated all dietary staff on food temperatures via service line policy How the facility will monitor the system: Administrator has developed an audit tool to conduct kitchen sanitation audits 3 x's per week for	09/02/2018

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	Dietary Cook removed the thermometer and again wiped it off with the rag in her hand. She wiped the thermometer off with the rag after checking the temperatures of the starch, ground meat, puree vegetables, puree starch, and puree meat. Interview with the DFM on 8/2/18 at 2:50 p.m., indicated the Cook should have used an alcohol wipe to clean off the thermometer in between each food item. The current facility policy titled "Food Temperatures on Service Line" provided by the DFM, on 8/2/18 at 2:08 p.m., indicated "Wash, rinse and sanitize a dial face thermometer with alcohol wipe. Re-sanitize the thermometer after each use." 3.1-21(i)(3)		4 weeks Dietary manager will audit the cooks on food temperatures thermometer sanitation and re sanitation 3'x s per week for 4 weeks and then monthly for 6 months The QAPI team will review the results of the audit during monthly QAPI meetings until 100% compliance has been achieved Completion Date: 9/2/18	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable			

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	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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP			

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	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 an infection control program was followed related to the lack of a water management plan to protect high risk residents residing in the facility. This had the potential to affect the 3 high risk residents residing in the facility. Finding includes: On 8/2/18 at 2:50 p.m., the Administrator provided a binder with the copy of the guide (CMS toolkit) for developing a water management program to reduce Legionella (bacteria) growth and spread in a building titled, "A practical guide to implementing industry standards." The Administrator indicated this was the facility's policy and had contacted her corporate office for further information and was waiting for a reply. She was unaware and was not familiar of any plan or policy needed to protect the residents against Legionella. Interview with the Administrator on 8/2/18 at 3:00 p.m., indicated she had spoken to corporate and he and the previous Administrator were working on putting something into place because it had been a concern last year.	F 0880	Corrective actions for residents affected: Regarding the Water Management Plan, no residents were identified as being immediately affected by the deficient practice How other residents will continue to be identified: All residents have the potential to be affected by the deficient practice: System Revision: An audit tool has been in place to monitor, cooling tower, water heaters, sinks , bathrooms, ice machine and water fountain by maintenance Water management program is now being followed How the facility will monitor the system: The administrator/Designee will monitor the audits weekly x's 4 weeks then monthly thereafter to ensure compliance	09/02/2018

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	155458	A. BUILDING 00 B. WING	08/03/2018

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	On 8/3/18 at 9:00 a.m., the Administrator provided an undated "Water Management Policy", which identified potential areas at risk, control measures, and monitoring. Interview with the Administrator at that time, indicated she had no idea if or when the policy had been implemented. She provided an incomplete monthly inspection log and indicated none of the monitoring had been completed. Observation during the survey indicated there were no whirlpool tubs or fountains at the facility. The Resident Census and Condition form indicated there were 3 of 25 residents receiving respiratory therapy and 0 residents receiving chemotherapy. Interview with the Director of Nursing on 8/3/18 at 1:00 p.m., indicated there were no residents who smoke and/ or were 50 years old or younger. 3.1-18(b)(1)		The water management policy and plan will be discussed at the monthly QAPI meeting for 6 months to ensure facility is 100% compliant Completion Date: 9/2/18	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to paint patches, peeling, chipped, and scratched paint, dried food substances and/or spillage on wheel chairs and walls, missing cove bases, peeling and chipped wood, marred and scratched walls, displaced heat register screens, loose closet door handles, and	F 0921	Corrective action for residents affected: The facility has taken the following action concerning the areas identified on the CMS-2567: Room # 2- Patches of missing paint, peeling paint and cove bases has been repaired by	09/02/2018

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	missing curtain hooks for 2 of 2 halls. (The Front and Back halls) Findings include: During the Environmental Tour on 8/1/18 at 10:35 a.m. with the Administrator, the following was observed: 1. Front Hall a. Room 2, there were patches of missing paint and peeling paint near bed 2. There was dried food substances on the wheelchair near bed 1. There were no cove bases along the walls. Two residents shared the room. b. Room 5, there were no cove bases along the walls. Two residents shared the room. c. Room 7, the bedside table near bed 2 had peeling and chipped wood. The walls were marred and had peeling paint. Two residents shared the room. d. Room 8, there were patches of missing paint on the walls. One resident resided in the room. 2. Back Hall a. Room 10, there were no cove bases along the walls. The screen from the heat register was hanging down and resting on the floor. Two residents resided in the room. b. Room 14, the wall next to bed 1 had dried food spillage. The wood behind the head of bed 1 had chipped and scratched paint. The closet door had loose handles. There were no cove bases along the walls. Two residents shared the room.		maintenance. Dried food substances on wheelchair has been cleaned. Room # 5- Cove bases has been applied by maintenance Room # 7- Bedside table has been replaced and walls has been repaired by maintenance Room # 8- Paint patches has been repaired by maintenance Room # 10- Cove Bases has been applied and screen to heat register has been cleaned and re-attached Room # 14- Dried spillage has been cleaned and the wood behind the head of bed has been repainted, Closet door handle has been re-attached and cove bases has been applied by maintenance Room # 17- Curtain hooks has been replaced and baseboards along the walls also has been replaced by maintenance How other residents will continue to be identified All residents have the potential to be affected by the deficient practices System Revision: All resident rooms will be inspected, repaired and repainted weekly as needed All staff to be in-serviced held on timely notification of environmental issues to maintenance or Administrator by 9/2/18 All wheelchairs are scheduled for inspection and preventative	

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	c. Room 17, the privacy curtains had missing hooks. There were no base boards along the walls. Two residents shared the room. Interview at the time with the Administrator indicated she was currently without a Maintenance Director and was interviewing potential candidates. All the above areas were in need of cleaning and/or repair. 3.1-19(f)		maintenance monthly and as needed How the facility will monitor the system: To ensure compliance, the maintenance director or designee will audit rooms and wheelchairs weekly for 4 weeks, and monthly for 6 months. The results will be reviewed monthly at QAPI meeting until 100% compliance has been achieved Completion Date: 9/2/18	
F 9999 Bldg. 00	3.1-14 Personnel (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment...The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	F 9999	Corrective actions: Incomplete Physical Exams for the following staff: Dietary Aide 1, C.N.A 1, C.N.A 2, QMA 1, Laundry Aide 1, Activity Director and Administrator will be completed by 9/2/2018 Incomplete TB Testing for the following staff: Administrator, QMA 1 and QMA 2, TB Testing to be completed by 9/2/2018 Incomplete required Dementia Training for the following staff: QMA 2, Laundry Aide 1 and Activity Director will complete (3) hours of Dementia Training by 9/2/2018 Human Resources Director is	09/02/2018

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	(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete related to initial/annual TB (tuberculosis) testing not completed, physical exams not completed by a Physician, and no annual dementia training for 8 of 10 employee files reviewed. (Dietary Aide 1, CNA 1, CNA 2, QMA 1, QMA 2, Laundry Aide 1, Activity Director, and Administrator) Findings include: 1. On 8/1/2018 at 10:00 a.m., the Employee files were reviewed and the following was noted: No physical exams and/or exams signed by a nurse rather than a Physician or Nurse Practitioner: a. Dietary Aide 1, hired on 4/23/18, physical exam signed by a LPN. b. CNA 1, hired on 5/11/18, physical exam signed by the DON. c. CNA 2, hired on 5/11/18, no physical examination completed. d. Administrator, hired on 7/12/18, no physical exam completed. e. QMA 1, hired on 7/12/18, no physical exam		reviewing all current employee files for completion of the completion of the (6) hours Dementia Training, Physical Exams and TB Testing. Any employees discovered to be deficient in any or all areas will receive notification as to information needed by date as indicated by HR Director. System Revision: Human Resource Director was in-serviced by Administrator on 8/14/18 on maintaining personnel files. The Administrator or Designee will provide required Dementia Training as scheduled, The (6) hours required (3) hours are completed upon initial orientation and the final 3 hours are offered monthly to be completed within 6 months of hire. HR is auditing all personnel file for Physical Exams and TB Testing compliance. HR will monitor compliance by auditing monthly and notifying employees, Department Managers and Administrator of status and pending sessions to be completed. How the facility will monitor the system: HR will randomly audit employee files weekly for accuracy for four weeks and then monthly for 3 months, thereafter until	

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	completed. No TB testing completed: a. Administrator, hired on 7/12/18, no initial TB test completed. b. QMA 1, hired on 7/12/18, no initial TB test completed. c. QMA 2, hired on 7/2/98, last TB recorded was 7/9/17. 2. The annual and 6 hour dementia training logs were reviewed on 8/1/18 at 10:00 a.m., The following employees were lacking the annual 3 hours of dementia training for 2017: a. QMA 2, hired on 7/2/1998. b. Laundry Aide 1, hired on 7/24/1992. c. Activity Director, hired on 2/6/15. Interview with the Business Office Manager on 8/1/18 at 1:00 p.m., indicated the above personal files were incomplete.		compliance has been maintained for two consecutive quarters. The results will be reviewed by the QAPI committee monthly for continued compliance. Completion Date: 9/2/18	