STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00280522. Complaint IN00280522 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: November 26, 27, 28, 29, and December 3, 2018 Facility number: 000129 Provider number: 155224 AIM number: 100266780 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 3 Medicaid: 103 Other: 12 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2018.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 0550	**F550 Resident Rights/Exercise**	01/02/2019

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	Based on observation, record review, and interview the facility failed to ensure dignity when serving meal trays for 2 of 2 meal services observed and 1 of 1 resident reviewed with a "STOP" sign on her door. (Main Dining Room, Resident 28, Resident 17, Resident 175, Resident 58, Resident 113, Resident 7, Resident 96, Resident 110, Resident 35, Resident 224, Resident 118) Findings include: 1. On 11/26/18 at 1:14 p.m., LPN (Licensed Practical Nurse) 1 was observed to deliver Resident 28's lunch to him. LPN 1 was observed to knock on the resident's door and enter the room without waiting to be acknowledged. 2. On 11/26/18 at 1:17 p.m., LPN 1 was observed to deliver Resident 17's lunch to him. LPN 1 was observed to knock on the resident's door and enter the room without waiting to be acknowledged. 3. On 11/26/18 at 1:27 p.m., CNA (Certified Nurse Aide) 7 was observed to deliver Resident 175's lunch to him. CNA 7 was observed to enter the resident's room without knocking or announcing herself. 4. On 11/26/18 at 1:51 p.m., CNA 13 was observed to deliver Resident 58's lunch to him. CNA 13 was observed to knock on the resident's door and enter the room without announcing herself or waiting to be acknowledged. 5. During an observation on 11/26/18 at 1:07 p.m., CNA 2 called the residents, who needed to be assisted, "feeders." Other residents were within hearing distance of CNA 2.		**of Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Staff are ensuring dignity during dining for residents by ensuring that they are knocking on doors and waiting to be acknowledged, Resident #28, Resident 17, Resident 175, Resident 58, Resident 113, Resident #7, Resident 96, Resident 110, Resident 35, Resident 224, Resident 118. · IDT team reviewed stop sign intervention for resident # 35 it was discontinued and removed on 12-3-18 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All Staff will be In-serviced on resident rights with an emphasis on dignity completed by DNS/designee for LPN #1, C.N.A #7, #13, #2, #10, #3, Nurse's Aide #1, C.N.A.#5 by Dec 31, 2018. · IDT team members were in-serviced on appropriate interventions when determining resident safety. · An audit will be conducted of residents who have stop signs	

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	6. During an observation on 11/26/18 at 1:25 p.m., CNA 7 was observed to enter Resident 113's room without knocking or waiting to be acknowledged. 7. During an observation on 11/26/18 at 1:27 p.m., CNA 10 was observed to enter Resident 7's room as she was knocking, without waiting to be acknowledged. 8. During an observation on 11/26/18 at 1:50 p.m., CNA 3 said, "knock, knock, " as she entered Resident 96's room, without waiting to be acknowledged. 9. During an observation on 11/26/18 at 1:51 p.m., CNA 3 said, "knock, knock, " as she entered Resident 110's room without waiting to be acknowledged. During an interview with CNA 10 on 11/26/18 at 1:25 p.m., she indicated staff was to knock and wait to be acknowledged before entering resident rooms. 10. On 11/27/18 at 8:43 a.m., Nurse Aide 1 was observed to knock on Resident 224's door, say nursing and proceed to walk in without waiting. 11. On 11/27/18 at 8:36 a.m., CNA 5 was observed to knock on Resident 118's door, say nursing and proceed to walk in without waiting. 12. On 11/26/18 at 3:37 p.m., the record for Resident 35 was reviewed and indicated she had had a fall on 11/19/18 with injury due to unwitnessed fall. Resident 35 has severe cognitive impairment per the Significant Change MDS (Minimum Data Set) dated 9/13/18. Diagnoses included On 11/27/18 at 1:58 p.m., Resident 35 was observed sitting up in her wheelchair sitting in		as a safety intervention to ensure appropriateness of the intervention by DNS/Designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · In-service will be completed by DNS/designee for all staff related to resident rights, to include knocking and waiting for acknowledgement (Dignity)when entering resident rooms, and for using appropriate names when referring to residents. · Observational rounds will be completed daily by DNS/Designee to ensure that staff are knocking on doors and waiting for acknowledgement prior to entering resident rooms and using appropriate names when referring to residents. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of the Dignity and Privacy CQI Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the	

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	hallway by the stop sign across her room doorway, smiling and pleasantly confused. The resident indicated the stop sign prevented her from entering her room. On 11/27/18 at 8:54 a.m., Resident 35 was observed laying in on a lowered bed, scoop mattress, and a fall mat in place at bedside. The stop sign was dangling from velcro, attached to the left side of the door. On 11/29/18 at 12:06 p.m., the orders indicated a stop sign when resident is out of the room, dated 11/29/18. On 12/03/18 at 12:07 p.m., RN (Registered Nurse) Consultant 1 indicated the stop sign was a fall intervention so staff would notice her going into her room. The resident was not able to remove the stop sign to enter her room. On 12/3/18 at 11:48 a.m., RN Consultant 1 provided the current facility policy, "Resident Rights," revised date of 11/16. The Policy indicated all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care. 3.1-3(t)		QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	
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			

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	a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State 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:			

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	(i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is 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.			

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	§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual 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 interview and record review, the facility failed to provide a Notice of Transfer to residents, and/or resident representative, as soon as was practicable for 2 of 3 residents reviewed. The transfer information was provided to the receiving hospital and not to the resident or resident representative. (Resident 38, Resident 99) Findings include: 1. On 11/26/18 at 3:36 p.m., the family member of Resident 38 indicated the resident had been transferred to the hospital several times recently. The family member indicated they were not always notified when the resident was sent and were never given a transfer notice in writing. The clinical record for Resident 38 was reviewed on 11/27/18 at 2:11 p.m. The record indicated Resident 38 had been transferred to the hospital on 11/26/18. The record lacked documentation that a Notice of Transfer or Discharge was provided to the resident or resident representative, in a practicable time period. On 12/13/18 at 1:55 p.m., LPN 1 indicated when a resident was transferred, the facility would send	F 0623	**F623 Notice Requirements Before Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Family and Resident notification of transfers were completed for Residents 38 and 99 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that transfer from the facility have the potential to be affected by the alleged deficient practice. · All residents who were transferred to the hospital within the last 30 days were reviewed by DNS/Designee to ensure the resident and resident representative was provided the Notice of Transfer **What measures will be put into**	01/02/2019

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	information including, but not limited to, a bed hold policy, Notice of Transfer form, the physician's orders, an observation form, 2 (two) face sheets, and lab results in a packet to the hospital. 2. On 11/26/18 at 10:23 a.m., Resident 99 indicated she had been sent to the hospital several times and had not been provided a Notice of Transfer or Discharge. On 11/28/18 at 1:30 p.m., Resident 99's chart was reviewed. She had diagnoses that included, but were not limited to, epilepsy, chronic pain, and cognitive communication deficit. A quarterly MDS (Minimum Data Set,) dated 10/9/18, indicated Resident 99 was cognitively intact. Progress notes, dated 8/5/18 at 4:16 p.m., indicated the resident exited the facility on a gurney and went by ambulance to the hospital. The transfer paper and bed hold policy were sent with the resident in the transfer packet. No documentation was found in the record that the resident or representative were provided a notice of transfer or discharge. Progress notes, dated 9/23/18 at 7: 35 a.m., indicated Resident 99 was sent to the hospital by ambulance. No documentation was found in the record that the resident or representative were provided notice of transfer or discharge. On 12/3/18 at 11:48 a.m., the current policy was provided on hospital discharge/transfer, with a revision date of 10/17. The policy included, but was not limited to, Nursing will complete an emergency transfer form and attach copies of the following information from the resident medical record... Notice of Transfer/Discharge... 3.1-12(a)(8)(D)		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted by ED/designee for Licensed staff on Bed Hold Policy and Procedure and Notification of Transfer by 12-31-18. · IDT will complete a review of the discharge chart for completion of the Notification of Transfer. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of the Hospital Readmission or Transfer CQI Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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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 interview and record review, the facility failed to provide notice of bed hold to residents or resident representatives as soon as was practicable for 3 of 3 residents reviewed. The bed hold information was provided to the receiving hospital and not to the resident or resident representative. (Resident 38, Resident 18,	F 0625	**F625 Notice of Bed Hold Before/Upon Transfer** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Family and Resident	01/02/2019

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	Resident 99) Findings include: 1. On 11/26/18 at 2:28 p.m., a family member of Resident 38 indicated the resident had been sent to the hospital several times recently. They stated they had not received a bed hold policy when the resident was transferred. The clinical record for Resident 38 was reviewed on 11/27/18 at 2:11 p.m. The record indicated Resident 38 had been transferred to the hospital on 11/26/18. The record indicated the facility employee to contact about the bed hold policy was the BOM (Business Office Manager) and gave the contact phone number. On 12/3/18 at 1:55 p.m., LPN 1 indicated when a resident was transferred, the bed hold policy, a transfer form, 2 (two) face sheets, the physician's orders, an observation form, and the resident's lab results were placed into a packet and sent with the transport service. LPN 1 indicated the forms were not given to the residents. 2. During a review of Resident 18's clinical record on 11/28/18 at 10:27 a.m., it indicated Resident 18 was cognitively intact. It further indicated Resident 18 was sent out to the hospital on 11/2/18 for bladder spasms. The clinical record lacked documentation that Resident 18 or his representative was provided a written copy of the bed hold policy. During an interview with the DON (Director of Nursing) on 11/28/18 at 11:59 a.m., she indicated a bed hold policy is sent in the hospital packet. She further indicated it is handed off to transport, and is not given directly to the resident or their representative.		notification of bed hold was completed for Residents 38, 18, and 99 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that transfer from the facility to the emergency room have the potential to be affected by the alleged deficient practice. · All residents who were transferred to the hospital within the last 30 days were reviewed by DNS/Designee to ensure the resident and resident representative was provided the Bed Hold Policy **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted by ED/designee for Licensed staff on Bed Hold Policy and Procedure and transfer form by 12-31-18. · IDT will complete a review of the discharge chart for completion of the Notification of Transfer and Bed Hold. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	3. On 11/26/18 at 10:23 a.m., Resident 99 indicated she had been sent to the hospital several times and had never received a written notice of a bed hold, and was not told about one. On 11/28/18 at 1:30 p.m., Resident 99's chart was reviewed. She had diagnoses that included, but were not limited to, epilepsy, chronic pain, and cognitive communication deficit. A quarterly MDS (Minimum Data Set) dated 10/9/18 indicated Resident 99 was cognitively intact. Progress notes dated 8/5/18 at 4:16 p.m., indicated the resident exited the facility on a gurney and went by ambulance to the hospital and the transfer paper, bed hold policy were sent with the resident in the transfer packet. No documentation was found in the record that the resident or representative were provided written notice of the bed hold policy. Progress notes dated 9/23/18 at 7: 35 a.m., indicated Resident 99 was sent to the hospital by ambulance. No documentation was found in the record that the resident or representative were provided written notice of the bed hold policy. On 12/3/18 at 11:48 a.m., the current bed hold policy was provided by RN Nurse Consultant 1. The policy indicted, but was not limited to, the residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave. The resident's representative will be informed of there bed hold policy at the time of notification of transfer. The resident representative will be provided a copy of the bed hold policy upon request. The facility staff will document the notification to the resident and resident representative of the bed hold policy on the Emergency Resident Transfer Form. 3.1-12(a)(25)(26)		· The DNS/designee will be responsible for the completion of the Hospital Readmission or Transfer CQI Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	155224	A. BUILDING 00 B. WING	12/03/2018

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F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to develop and follow care plans for 3 of 12 residents. (Resident 175, Resident 118, Resident 30) Findings include: 1. On 11/27/18 at 8:15 a.m., Resident 175 was observed to be sitting in a chair, coloring a paper. Resident 175 indicated he was thirsty and his lips and mouth were dry. No fluids were observed at the bedside and the resident indicated the facility did not pass ice water on any of the shifts. On 11/27/18 at 1:25 p.m., Resident 175 was observed to be sitting on the side of his bed. Resident 175 had a chopped up hot dog on a bun for his lunch meal. He indicated he did not want his meat chopped up and did not want the hot dog. The facility "usually put gravy over all the food and he did not like gravy" and the facility did not offer him a substitute. He further indicated the facility did not offer snacks at bedtime. On 11/27/18 at 1:55 p.m., a half cup of red liquid was observed sitting on the rail outside of the resident's room. No fluids were observed in the resident's room. On 11/27/18 at 3:10 p.m., the resident was observed to have no fluid or ice water at the bedside. On 11/28/18 at 9:45 a.m., the resident was	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 175 no longer resides in facility · Resident 118 is receiving adequate hydration, per plan of care and physician orders. · Resident 118 has hx of frequent UTI's that is now listed in plan of care · Resident 30 is being offered activities per her plan of care **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents with history of UTI's will have history addressed	01/02/2019

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	observed to have no fluids or ice water at the bedside. On 11/28/18 at 2:16 p.m., the resident was observed to have no fluids or ice water at the bedside. On 11/29/18 at 7:30 a.m., no water cups or fluids were observed at the bedside. The clinical record for Resident 175 was reviewed on 11/28/18 at 8:54 a.m. Diagnosis included, but were not limited to, hypothyroidism, vitamin D deficiency, osteoarthritis, weakness, and dysphagia. The resident was admitted on 11/9/18. A care plan, dated 11/19/18, indicated the resident was at risk for fluid imbalance related to his intellectual disability. Interventions included, but were not limited to, the following: Encourage fluids. Record intake. The clinical record indicated the resident had received the following amounts of fluids for a 24 (twenty-four) period: 11/27/18: 720 ml (milliliters) 11/25/18: 520 ml 11/24/18: 600 ml 11/21/18: 480 ml 11/11/18: no fluid intake was recorded A care plan, dated 11/20/18. indicated the resident was on a mechanically altered diet related to his dyphagia. Interventions included, but were not limited to, the following: Honor known food preferences. Monitor food/fluid intake at meals.		in plan of care · All residents who reside on the cottage activity care plans were reviewed to ensure the care plan accurately reflected the resident's activity preferences **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by DNS/designee for all nursing staff to include provision of adequate hydration and activities of choice per plan of care. ·Observational rounds will by Customer Care Representatives daily to ensure that foods are being received per preference and that adequate hydration is being provided by staff for all residents per plan of care. ·An in-service will be facilitated by DNS/Designee to MDS/Designee to include infection history in plan of care. · Interviews with residents were completed by Customer Care Representatives to ensure that foods are being received per preference with tray cards changed and substitutes offered as needed. · Observational rounds were completed by DNS/designee to ensure adequate hydration is being provided by staff for all residents. ·Observational rounds will be	

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	Offer substitute if 50% or less of any meal is consumed. A physician's order, dated 11/14/18, indicated the resident was on a mechanical soft diet. Review of the resident's meal intake included the following: 11/27/18 at 6:47 p.m.: supper meal intake was 26-50% with no substitute offered. 11/27/18 at 1:41 p.m.: lunch meal intake was 26-50% with no substitute offered. 11/26/18 at 7:15 p.m.: supper meal intake was 1-25% with no substitute offered. 11/24/18 at 10:30 a.m.: breakfast meal intake was 16-50% with no substitute offered. 11/23/18 at 6:54 p.m.: supper meal intake was 26-50% with no substitute offered. 11/23/18 at 1:54 p.m.: lunch meal intake was 26-50% with no substitute offered. 11/23/18 at 9:15 a.m.: breakfast meal intake was 0 with no substitute offered. 11/22/18 at 9:52 p.m.: supper meal intake was 0 with no substitute offered. 11/21/18 at 6:51 p.m.: supper meal intake was 0 with no substitute offered. 11/21/18 at 1:56 p.m.: lunch meal intake was 0 with no substitute offered. 11/21/18 at 9:13 a.m.: breakfast meal intake was 1-25% with no substitute offered. 11/20/18 at 7:06 p.m.: supper meal intake was 26-50% with no substitute offered. 11/20/18 at 8:48 a.m.: breakfast meal intake was 26-50% with no substitute offered. 11/19/18 at 6:45 p.m.: supper meal intake was 1-26% with no substitute offered. 11/19/18 at 8:44 a.m.: breakfast meal intake was 0 with no substitute offered. The facility failed to encourage fluids and offer		completed by DNS/designee to ensure activities are being provided per plan of care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of the Hydration Management QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. · The DNS/designee will be responsible for the completion of the Care Plan Updating QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be	

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	substitutes, as per the care plan. On 12/3/18 at 8:15 a.m., the Director of Nursing (DON) indicated water should be passed on every shift. She further indicated care plans were developed by the MDS (Minimum Data Set) Coordinator for the residents. 2. On 11/26/18 at 11:53 a.m., Resident 118 was observed in her room lying in bed. She indicated she had frequent urinary tract infections ongoing for years. On 11/27/18 at 2:29 p.m., Resident 118's record was reviewed. She had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, Diabetes Mellitus, and personal history of urinary tract infections. A significant change MDS (Minimum Data Set), dated 9/10/18, indicated Resident 118 was cognitively intact. Physician's orders were reviewed for Resident 118. She had an order for Linezolid (antibiotic) 600 mg (milligram) by mouth: special instructions urinary tract infection -VRE (Vancomycin resistant Enterococci) twice a day 8:00 a.m. and 8:00 p.m., start date 11/22/18, end date 12/1/18. An event note, dated 6/25/18, indicated Resident 118 was on an antibiotic for a urinary tract infection. An event note, dated 10/11/18, indicated Resident 118 returned from an appointment with orders for a antibiotic for a urinary tract infection. Care plans were reviewed for Resident 118. There were no care plans that addressed Resident 118's diagnosis of personal history of urinary tract infections or frequent urinary tract infections. On 11/28/18 at 10:35 a.m., the MDS Coordinator indicated she believed Resident 118 had a		developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	diagnosis of frequent urinary tract infections and it was something the IDT (Interdisciplinary team) would discuss and decide if it needed added to the resident's care plan. On 12/3/18 at 11:48 a.m., the RN Consultant 1 provided the current policy on IDT Comprehensive Care Plan Review, with a revision date of 11/17. The policy indicated, but was not limited to, it is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and residents specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental, and psychological needs. Purpose is to create an organized, resident-centered meeting on a routine basis to improve communication with residents, resident families and/or representative regarding the resident's goals, total health status... Care plan review will be interdisciplinary an should include to the extent possible nursing, social services, activities, dietary, therapy, pharmacy and physician and certified nursing assistant(s). 3. During a review of Resident 30's clinical record on 11/28/18 at 7:59 a.m., it indicated Resident 30 was severely cognitively impaired. It further indicated her diagnoses included, but were not limited to, Diabetes Mellitus, non-Alzheimer's dementia, manic depression, PTSD (Post-Traumatic Stress Disorder), dementia with behavioral disturbance. A review of the care plans indicated the following: Resident is at risk for s/s (signs and symptoms) of depression. Interventions listed included, but were not limited to, encourage activities of			

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	interest. Resident is unable to make daily decisions without cues/supervision. Interventions listed included, but were not limited to, avoid assuming an overly protective attitude toward resident, calm resident if signs of distress develop during the decision making process, provide the resident opportunities to make decisions, respect resident rights to make decisions. At times, resident expresses preference of doing most leisure activities in the comfort of her room, requires much encouragement to participate in groups. Interventions listed included, but were not limited to, offer reassurance that she can leave activity when she wants to or come watch from a distance, praising all participation attempts active or passive. Give verbal reminders and escort to activities of interest such as musical entertainment, simple crafts, coloring, social opportunities, lovely nails, provide materials for independent activity use such as magazines, daily chronicles, coloring materials, etc. The following observations were made: 11/26/18 at 3:23 p.m., Resident 30 was walking the hallway, hitting and counting the pictures on the wall. Other residents observed in activities on the unit. 11/27/18 at 10:11 a.m., Resident 30 observed sitting in chair in room, talking to self, counting. Other residents observed in community area dancing with staff, listening to music. 11/27/18 at 10:14 a.m., Resident 30 was observed walking in the hall, hitting pictures on wall, counting, carrying purse on shoulder.			

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	11/27/18 at 10:14 a.m., Resident 30 was observed in the hallway. Laundry aide was observed telling Resident 30 to go to her room. Resident 30 was observed to run around and walk back to her room, counting as she went. 11/27/18 at 10:21 a.m., Resident 30 was observed in her room sitting in a chair at bedside, counting. 11/27/18 at 2:43 p.m., Resident 30 was observed in her room, door closed, counting to self. 11/27/18 at 2:53 p.m., Resident 30 observed sitting in her room, door closed, counting to self. Other residents on unit observed in activities playing trivia games. 11/27/18 at 3:00 p.m., Resident 30 observed walking in the hall, hitting the pictures and counting repetitively. CNA (Certified Nurse Aide) 8 observed to run down hall to Resident 30 and direct her back to her room, and shut the door. 11/28/18 at 11:21 a.m., Resident 30 was observed walking in the hallway, counting, hitting pictures on wall, opening and closing other resident doors. 11/28/18 at 11:22 a.m., Memory Care Facilitator/CNA 1/ Activity Director (one person with three titles) came down the hallway to Resident 30 and guided her into her room. She then indicated she was going to assist her to the restroom. 11/28/18 at 11:34 a.m., Memory Care Facilitator/CNA 1/ Activity Director was observed to take Resident 30 back to her room from the hallway. She then sat in a chair next to her chair to chat with her.			

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	During an interview with Activity Aide on 11/27/18 at 10:17 a.m., she indicated she will do some 1:1 activities or reading with Resident 30 in her room at times, but she was not on a 1:1 calendar. During an interview on 11/27/18 at 10:30 a.m., Memory Care Facilitator/CNA 1/ Activity Director indicated Resident 30 had preferences to not participate in activities or to eat in the main dining room. During an interview with CNA 8 on 11/28/18 at 11:29 a.m., she indicated staff does try to keep Resident 30 in her room due to keeping her out of the refrigerator. During a follow-up interview with Memory Care Facilitator/CNA 1/ Activity Director on 12/3/18 at 2:00 p.m., she indicated Resident 30's care plans indicated she should be offered activities of interest, and should not be kept in her room, but should be encouraged to attend activities. She further indicated Resident 30 was not able to make all preferences known, and needed cueing with daily decision making. She further indicated she would be revising her care plan to include activities of interest and to make it more individualized for Resident 30. On 12/3/18 at 11:48 a.m., the RN Consultant 1 provided the current policy on IDT Comprehensive Care Plan Review with a revision date of 11/17. The policy indicated, but was not limited to, "it is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and residents specific			

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	interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental, and psychological needs. Purpose is to create an organized, resident-centered meeting on a routine basis to improve communication with residents, resident families and/or representative regarding the resident's goals, total health status... Care plan review will be interdisciplinary an should include to the extent possible nursing, social services, activities, dietary, therapy, pharmacy and physician and certified nursing assistant(s)." 3.1-35(a) 3.1-12(a)(26)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.			

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	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed offer residents the ability to participate in care planning for 1 of 5 residents reviewed for care planning. (Resident 66) Findings included: On 11/26/18 at 9:11 a.m., Resident 66 indicated he hadn't been to a care plan meeting. On 12/3/18 at 7:56 a.m., the record for Resident 66 was reviewed. A care conference note dated 6/26/18 indicated a care conference was held and the resident attended. No further documentation of further care conferences were present. The Quarterly MDS (Minimum Data Set), dated 9/11/18, indicated Resident 66 was cognitively intact. On 12/3/18 at 7:56 a.m., Social Services Director 1 indicated they have invitations they hand out to the residents. They do an observation in the system, and indicated the last one she was able to find was 6/26/18. Care plan meetings are held quarterly and they were getting back on track due to having fairly new staff. On 12/3/18 at 11:48 a.m., the RN Consultant 1 provided the current facility policy, IDT (Intradisciplinary Team) Comprehensive Care Plan Review, revised 11/2017. The Policy indicated, but was not limited to, resident, resident's families or	F 0657	**F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 17 was invited to a care plan meeting. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · An audit was completed by SSD/designee to ensure all residents/responsible parties have received invitations to care conference in the last quarter. Care conferences were offered/scheduled/conducted based on the results of this audit. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by ED/designee for	01/02/2019

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	others as designated by resident will be invited to care plan review. 3.1-35(c)(2)(C)		Social Services Coordinator and Assistant to include Care Plan Meeting to include invitation of residents to care conference. · The IDT will review care plan schedule to ensure that SSD/designee has invited all residents and all responsible parties to Care Plan Conferences quarterly. · The SSD/designee will send invitations to resident/responsible party and will keep a copy of the written invitation as record of the resident being invited. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The SSD/designee will be responsible for the completion of the Care Plan Meeting QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been			

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	asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the			

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	discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on record review and interview, the facility failed to develop a discharge plan for 1 of 1 residents reviewed for discharge. A resident did not have a discharge care plan. (Resident 108) Findings include: On 11/27/18 at 11:27 a.m., the closed clinical record for Resident 108 was reviewed. Resident 108 had been discharged from the facility on 10/26/18. The admission MDS (Minimum Data Set) assessment, dated 10/18/18, indicated the resident had slight cognitive impairment. The MDS further indicated the resident expected to be discharged to the community. The clinical record lacked documentation of a discharge care plan. On 12/3/18 at 2:18 p.m., the SSD 1 (Social Service Designee) indicated the resident lacked a discharge care plan. The SSD presented a paper which she indicated she followed for resident's discharges. The SSD indicated the paper was not a discharge care plan. 3.1-12(a)(19)	F 0660	**F660 Discharge Planning Process** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #108 no longer resides at the facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by this practice. · All residents' charts were reviewed by Social Service Director/Designee to ensure a discharge plan had been developed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Regional Social Service Consultant/designee will conduct a Discharge Planning In-Service with Social Services Staff and Memory Care Facilitator by 12-31-18. · Every resident will have discharge plans documented in their medical record by SSD/designee.	01/02/2019

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			· The Social Services Director will initiate the Discharge Checklist upon admission, which will be reviewed by the IDT during morning meeting. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., What Quality Assurance Program will be put into place?** · The ED/designee will be responsible for the completion of a Discharge Planning CQI Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	
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			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to provide residents with assistance to maintain personal hygiene for 2 of 5 residents reviewed for ADL's (Activities of Daily Living). (Resident 32, Resident 56) Findings include: 1. On 11/27/18 (Tuesday) at 8:35 a.m., Resident 32 was observed to have greasy hair hanging in stands to her shoulders. She indicated she received a shower once every two weeks and would like to have two showers a week. On 11/28/18 at 10:27 a.m., Resident 32 was observed to be sitting in her recliner with hair appearing greasy. On 11/28/18 at 11:01 a.m., the DON provided the month of November Point of Care History which failed to indicate Resident 32 had received a shower from 11/1-11/28/18, and had only received partial baths on 14 of 28 days in November. The record lacked refusals of showers or care. On 11/28/18 at 3:17 p.m., the shower schedule was reviewed. The schedule indicated Resident 32 was to have a shower on Tuesday and Saturday. On 11/29/18 at 8:50 a.m., Resident 32 was observed sitting up in her recliner, smiling, and hair continued to appear greasy. On 11/29/18 at 11:25 a.m., the DON (Director of Nursing) provided the current care plans. The ADL care plan indicated resident needs assistance with ADLs including bed mobility,	F 0677	**F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents #32 and #56 are receiving assistance with bathing per preference and plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Interviews with residents were completed by Customer Care Representatives to ensure that showers are being received per preference with schedules, care plans, and profiles changed as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by DNS/designee for all staff to include appropriate communication with residents	01/02/2019

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	transfers, eating and toilet use related to: hx of CVA (Cerebral Vascular Accident), and COPD (Chronic Obstructive Pulmonary Disease) with shortness of breath upon exertion, dated 12/08/16. Interventions included, but were not limited to, provide shower two times per week, partial bath in between. On 12/3/18 at 3:03 p.m., DON Consultant 1 indicated it was the resident's preference for when they received a shower. 2. On 11/26/18 at 9:14 a.m., Resident 56 was observed sitting in her Broda Chair. She was observed to have body odor. Resident 56 was unable to communicate any information about her personal hygiene. On 11/27/18 at at 8:31 a.m., Resident 56 was observed sitting in the dining room. She was observed to have body odor. On 11/28/18 at 3:45 p.m., Resident 56's record was reviewed. She had diagnoses that included, but were not limited to, bipolar disorder, diffuse traumatic brain injury without loss of consciousness, and chronic pain syndrome. A quarterly MDS (Minimum Data Set) dated 9/18/18 indicated Resident 56's cognition was severely impaired. Shower sheets were reviewed for October and November 2018. Resident 56 should have received 9 showers for October, and received 5. For the month of November Resident 56 should have received 9 showers, she received 1. Care Plans were reviewed and indicted Resident 56 should be offered showers two times per week. On 11/28/18 at 3:16 p.m., LPN 3 indicted the second floor only had one shower aide at the		regarding resident's bathing preferences and provision of ADL assistance with bathing. · Observational rounds will be conducted by Customer Care Representatives and DNS/Designee daily to ensure that showers are being received per preference. · An in-service will be completed by DNS/designee for all staff to document and communicate refusals of bathing and ADL care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of the skin management program QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	moment. On 11/28/18 at 4:10 p.m., the Director of Nursing indicated the unit manager kept track of the shower sheets as they came in, and the desk nurse signs off on the shower sheets and gave to the unit manager to be turned in. 3.1-38(a)(1) 3.1-38(a)(2)(A)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure residents received activities based on their individual needs and preferences for 1 of 3 residents reviewed for activities. .(Resident 30) Findings include: During a review of Resident 30's clinical record on 11/28/18 at 7:59 a.m., it indicated Resident 30 was severely cognitively impaired. It further indicated her diagnoses included, but were not limited to, Diabetes Mellitus, non-Alzheimer's dementia, manic depression, PTSD (Post-Traumatic Stress	F 0679	**F679 Activities Meet Interest/Needs Each Resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 30 is now having 1:1 Activity's being offered to her with an update to her preferences for Individualized Activities to her Plan of Care. **How will you identify other residents having the potential to be affected by the same**	01/02/2019

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	Disorder), dementia with behavioral disturbance. A review of the care plans indicated the following: Resident is at risk for s/s (signs and symptoms) of depression. Interventions listed included, but were not limited to, encourage activities of interest. Resident is unable to make daily decisions without cues/supervision. Interventions listed included, but were not limited to, avoid assuming an overly protective attitude toward resident, calm resident if signs of distress develop during the decision making process, provide the resident opportunities to make decisions, respect resident rights to make decisions. At times, resident expresses preference of doing most leisure activities in the comfort of her room, requires much encouragement to participate in groups. Interventions listed included, but were not limited to, offer reassurance that she can leave activity when she wants to or come watch from a distance, praising all participation attempts active or passive. Give verbal reminders and escort to activities of interest such as musical entertainment, simple crafts, coloring, social opportunities, lovely nails, provide materials for independent activity use such as magazines, daily chronicles, coloring materials, etc. The following observations were made: 11/26/18 at 3:23 p.m., Resident 30 was walking the hallway, hitting and counting the pictures on the wall. Other residents observed in activities on the unit. 11/27/18 at 10:11 a.m., Resident 30 observed		**deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents reviewed for activity participation. Preferences and individualized activities of interest and programming added to the plan of care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Regional Support/designee will conduct an In-Service with Activity Director to ensure activities meet the interests and the physical, mental, and psychosocial well-being of each resident by 12-31-18. · Activity participation and interests will be reviewed Quarterly by AD. · Plan of Care will be reviewed and updated Quarterly by AD in response to resident assessment, interests, and needs. · Observational rounds will be conducted daily by DNS/Designee to ensure activities are being provided to residents per plan of care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	sitting in chair in room, talking to self, counting. Other residents observed in community area dancing with staff, listening to music. 11/27/18 at 10:14 a.m., Resident 30 was observed walking in the hall, hitting pictures on wall, counting, carrying purse on shoulder. 11/27/18 at 10:14 a.m., Resident 30 was observed in the hallway. Laundry aide was observed telling Resident 30 to go to her room. Resident 30 was observed to run around and walk back to her room, counting as she went. 11/27/18 at 10:21 a.m., Resident 30 was observed in her room sitting in a chair at bedside, counting. 11/27/18 at 2:43 p.m., Resident 30 was observed in her room, door closed, counting to self. 11/27/18 at 2:53 p.m., Resident 30 observed sitting in her room, door closed, counting to self. Other residents on unit observed in activities playing trivia games. 11/27/18 at 3:00 p.m., Resident 30 observed walking in the hall, hitting the pictures and counting repetitively. CNA 8 observed to run down hall to Resident 30 and direct her back to her room, and shut the door. 11/28/18 at 11:21 a.m., Resident 30 was observed walking in the hallway, counting, hitting pictures on wall, opening and closing other resident doors. 11/28/18 at 11:22 a.m., the Memory Care Facilitator/CNA 1/Activity Director came down the hallway to Resident 30 and guided her into her room. She then indicated she was going to assist her to the restroom.		**into place?** · The AD/designee will be responsible for the completion of an Activities QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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11/28/18 at 11:34 a.m., the Memory Care Facilitator/CNA 1/Activity Director was observed to take Resident 30 back to her room from the hallway. She then sat in a chair next to her chair to chat with her.

During an interview with Activity Aide on 11/27/18 at 10:17 a.m., she indicated she will do some 1:1 activities or reading with Resident 30 in her room at times, but she was not on a 1:1 calendar.

During an interview on 11/27/18 at 10:30 a.m., the Memory Care Facilitator/CNA 1/Activity Director indicated Resident 30 had preferences to not participate in activities or to eat in the main dining room.

During an interview on 11/27/18 at 10:37 a.m., LPN 2 indicated Resident 30 did not receive 1:1 activities and eats in her room, per management request. She further indicated she eats 100% of her meals when she eats in her room, and eats much less if in the dining room. She further indicated she stays in her room most of the time, coming out to the hallway to count and hit on the pictures. She indicated 1:1 activities had not been tried with Resident 30, " but, they probably need to." Resident 30 is redirected to her room most of the time because she upsets other residents. Staff does not encourage her in group activities for this reason.

During an interview with CNA 8 on 11/28/18 at 11:29 a.m., she indicated staff does try to keep Resident 30 in her room due to keeping her out of the refrigerator.

During a follow-up interview with the Memory

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	Care Facilitator/CNA 1/Activity Director on 12/3/18 at 2:00 p.m., she indicated Resident 30's care plans indicate she should be offered activities of interest, and should not be kept in her room, but should be encouraged to attend activities. She further indicated Resident 30 was not able to make all preferences known, and needed cueing with daily decision making. She further indicated Resident 30 enjoyed getting her nails painted and listening to music, so she would be implementing these as activities on a regular basis. During a review of the current policy, " Activities," revised 1/06, it indicated, " It is the policy of this facility to provide for a ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment. 3.1-33(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	F 0685	**F685 Treatment/Devices to**	01/02/2019

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	Based on observation, interview, and record review, the facility failed to provide care to maintain a resident's hearing and vision for 1 of 2 residents reviewed. A resident did not see an audiologist or ophthalmologist after losing his hearing aids and glasses. (Resident 38) Findings include: On 11/26/18 at 9:10 a.m., Resident 38 was observed to be sitting on the locked dementia unit in the lobby sleeping. The resident did not have hearing aids in or glasses on. LPN 1 indicated the resident's hearing aids and glasses had been lost for several months and the facility had not been able to find them. The clinical record for Resident 38 was reviewed on 11/27/18 at 2:11 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, psychosis, and repeated falls. A quarterly MDS (Minimum Data Set) assessment, dated 7/20/18, indicated the resident had moderate difficulty hearing, moderate vision impairment and had hearing aids and glasses. An admission MDS assessment, dated 9/14/18, indicated the resident had highly impaired hearing difficulty, moderate vision impairment and did not have hearing aids or glasses. The MDS further indicated the resident had severe cognitive impairment. Physician's orders, dated 1/22/18 and 9/7/18, indicated the resident may be seen by the podiatrist, dentist, optometrist, and audiologist. A progress note, dated 3/28/18 at 12:14 p.m., indicated the resident was missing his hearing aids. The facility lacked documentation of when the resident lost his glasses but the Administrator		**Maintain Hearing/Vision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 38 has been referred to be seen by the Optometrist and Audiologist on the next available visit. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Residents who utilize glasses and hearing aides were assessed for devices being in good function. Referrals to Optometrist and Audiologist were made as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Regional SS Support/designee will conduct an In-Service with the Social Service Director with policy/procedure to ensure that residents are provided with vision and hearing services as needed. · Vision/Hearing needs will be assessed Quarterly during the scheduled assessments. · Referrals to the	

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	155224	A. BUILDING 00 B. WING	12/03/2018

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	indicated the resident had lost them prior to his starting employment with the facility in August, 2018. A progress note, dated 10/15/18 at 4:07 p.m., indicated the resident had been seen on 10/10/18 by the optometrist. Review of the consultation note indicated the resident had cataracts, hyperopic astigmatism (one or both meridians are farsighted), and presbyopia (a visual condition in which loss of elasticity of the lens of the eye causes defective accommodation and inability to focus sharply for near vision in both eyes.) A progress note, dated 10/15/18 at 4:21 p.m., indicated the resident had been seen by an Audiologist on 10/9/18. Review of the consult indicated the resident could not be tested due to the resident being unresponsive. On 12/2/18 at 2:40 p.m., the Administrator indicated the facility had never located the resident's hearing aids or glasses and thought they had been thrown away by the resident. He indicated the resident's spouse would not agree to cataract surgery for the resident and would not pay to replace the hearing aids. The current facility policy, dated 12/2017, and obtained from the Administrator on 12/3/18 at 11:48 a.m., indicated the facility was responsible to exercise care for the resident's property from loss or damage. The current facility policy, dated 1/2006, and obtained from RN Consultant 1 on 12/3/18 at 11:48 a.m., indicated the facility was to ensure that residents were provided with vision and hearing services as needed.		Optometrist/Audiologist will be made as needed to ensure residents are provided with vision and hearing services as needed. · ED/designee will ensure residents who use hearing aids/glasses, devices are available and used pre plan of care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The SSD/designee will be responsible for the completion of the Vision/Hearing QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	3.1-39(a) 3.1-39(b)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview, record review, and observation, the facility failed to prevent residents who entered the facility without skin impairment from developing pressure related injuries for 3 of 4 residents reviewed for pressure. (Resident 32, Resident 7, Resident 95) Findings include: 1. On 11/27/18 at 8:37 a.m., Resident 32 was observed sitting up in her recliner watching TV. She indicated she had a sore on her bottom and didn't know how long she had had it or why she developed it. She further indicated the facility had been using medication on it and she asked them to stop. On 11/28/18 at 3:23 p.m., RN 1 was observed to	F 0686	**F686 Treatment to Prevent/Heal Pressure Ulcer** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 32, 7 and 95 are receiving wound care and preventive interventions per wound care nurse recommendations and MD orders. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that have wounds have the potential to be	01/02/2019

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	check Resident 32 for pressure area to her buttocks. She indicated the area on her mid inner right buttock was pressure and appeared burgundy to slightly purple, approximately the size of a half dollar coin with a small area approximately 0.2 cm(centimeters) with the appearance of having been open on the inner edge. The color of the area didn't change when RN 1 pressed on it. Resident 32 indicated the area had been there about a month. RN 1 educated resident 32 on changing position. On 11/28/18 at 3:42 p.m., LPN 3 indicated skin assessments were completed on days and nights per the nurses, on the weekly summary. On 11/28/18 at 4:22 p.m., the Director of Nursing provided the last 30 days of weekly summaries. The most recent was dated 11/18/18 at 6:20 p.m., and failed to indicate any skin impairment. On 11/28/18 at 4:09 p.m., the Director of Nursing indicated the skin assessments were completed weekly. They did monthly skin sweeps, but it had not been done for this month. On 11/28/18 at 4:10 p.m., the record for Resident 32 was reviewed. The record indicated an order for Risamine (menthol-zinc oxide) ointment 0.44-20.6% topical, apply every shift as preventative, dated 6/12/18. The November treatment record indicated the ointment had been applied twice daily for the month. The Annual MDS (Minimum Data Set), dated 9/6/18, indicated Resident 32 was cognitively intact. The care plans indicated Resident 32 needed assistance with ADL's (Activities of Daily Living)		affected by the alleged deficient practice. · An audit was completed by DNS/designee on December 31, 2018 to identify all residents with current wounds and to ensure that appropriate treatment orders were in place based on most recent MD or wound nurse recommendations. · Licensed staff will be re-educated by DNS/designee related to skin management policy, to include weekly skin assessments, documentation and implementation of any recommendations from wound nurse by December 31, 18. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Weekly skin sweeps will be completed by DNS/designee to ensure wounds are identified and the treatments are appropriate for identified residents and that physician orders are followed by licensed staff. · DNS/designee will obtain and review weekly skin assessments to ensure that wounds are identified, and recommendations/orders are implemented timely. · DNS/Designee will conduct rounds daily to ensure residents with wounds or potential to develop wounds are receiving treatment and interventions per	

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	including bed mobility, transfers, eating and toilet use related to Hx (history) of CVA (Cerebral Vascular Accident) and COPD (Chronic Obstructive Pulmonary Disease) with shortness of breath. On 12/3/18 at 1:42 p.m., the Wound Care Nurse and RN Consultant 1 indicated they had gone to Resident 32's room the evening of 11/28/18, and indicated the area was not pressure, it was blanching, and dime size area that was scaly and pink. Wound Care Nurse indicated she did a skin assessment at that time. On 12/3/18 at 11:48 a.m., the RN Consultant 1 provided the current facility policy, Skin Management Program, revised date 4/2018. The Policy indicated, but was not limited to, Stage I pressure injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema which may appear differently in darkly pigmented skin. .... any skin alterations noted by direct care givers during daily care and /or shower days must be reported to the licensed nurse for further assessment... Facility skin sweeps (head-to-toe assessments) are conducted monthly to assess all residents' current skin condition and to ensure appropriate preventative measures are in place. 2. On 11/26/18 at 4:04 p.m., Resident 7 was observed to be lying in bed. Resident 7 indicated he had a wound on his left heel and had a dressing on it. No pressure relieving devices were noted to be on the resident and the resident's heels were not elevated. On 11/27/18 at 9:22 a.m., Resident 7 was observed to be lying in bed. Heels were not elevated and no pressure relieving devices were noted to be in place.		plan of care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of a Skin Management QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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On 11/27/18 at 3:10 p.m., Resident 7 was observed to be lying in bed. Heels were not elevated and no pressure relieving devices were observed to be in place.

On 11/28/18 at 9:27 a.m., the Wound Nurse was observed to change the resident's left heel dressing and apply a padded boot to the resident's left ankle and foot area. The area was open and pink with the margins clear. The Wound Nurse indicated the area was still draining slightly.

The clinical record for Resident 7 was reviewed on 11/28/18 at 11:09 a.m. Diagnosis included, but were not limited to left hemiplegia and generalized muscle weakness. A significant change MDS (Minimum Data Set) assessment, dated 10/27/18, indicated the resident had slight cognitive impairment and had no pressure injuries but was at risk for pressure wounds.

A physician's order, dated 11/13/18, indicated the resident was to have a heel protector to the left foot at all times, may remove for care, indicated as a preventative measure.

A care plan, dated 11/13/18, indicated the resident had impaired skin integrity. Interventions included, but were not limited to, heel protector to left foot at all times, may remove for care.

A wound management form, dated 11/13/18 at 10:58 a.m., indicated the resident was observed with a stage 2 (two) pressure wound to the left heel area, measuring 2.4 cm (centimeters) in length by 2.5 cm in width. The form indicated the wound was a fluid filled blister. A stage 2 pressure wound was described as a partial thickness loss

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	of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough and may also present as an intact or open/ruptured serum filled blister On 12/3/18 at 2:15 p.m., the Wound Nurse indicated the wound was acquired at the facility and the resident should wear the heel protector. 3. During a review of Resident 95's clinical record on 11/28/18 at 9:05 a.m., it indicated Resident 95 was cognitively intact. It further indicated diagnoses that included, but were not limited to, anemia, coronary artery disease, heart failure, viral hepatitis, fibromyalgia, and chronic pain. A review of the orders indicated the following: 11/20/18 - calmoseptine to coccyx, topical BID (twice daily) During an observation on 11/26/18 at 9:43 a.m., Resident 95 indicated she had a pressure wound on her right buttock. She further indicated the left buttock was healed. During an observation on 11/27/18 at 8:55 a.m., Resident 95 indicated she needed wound care on right buttock. She further indicated the wound was open. During an observation on 11/27/18 at 10:55 a.m., Resident 95 was observed sitting in her wheelchair at the nurses' station. During an observation on 11/27/18 at 2:35 p.m., Resident 95 was observed sitting in her wheelchair at the nurses' station. During an observation of Resident 95's buttock wound on 11/29/18 at 1:15 p.m., it was			

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	approximately the size of a small pencil eraser, red, with top layer of skin sloughed off. The edges were defined, without the appearance of scratches. During an interview with LPN 3 on 11/29/18 at 1:25 p.m., she indicated she would stage Resident 95's buttock wound a Stage 2 (Pressure injury: Partial thickness skin loss with exposed dermis. Wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible. Granulation tissue, slough and eschar are not present.) She further indicated she had not known about the wound until now, but had assisted with applying topical creams to Resident 95's buttocks. During an interview with the Wound Care Nurse on 12/3/18 at 1:45 p.m., she indicated Resident 95 would make false accusations, and had a history of scratching wounds open on her buttocks for attention. She further indicated 11/29/18, was the first she had heard of the open wound on Resident 95's right buttock. When queried she staged the wound as a Stage 2. She indicated a wound treatment was now in place. During a review of the current policy, " It is the policy of [name of facility] to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers...receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 3.1-40(a)(1)			

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F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to apply a palm protector and positioning devices as ordered, by the physician for 1 of 2 resident's reviewed for position, mobility. (Resident 94) Findings include: On 11/26/18 at 9:23 a.m., Resident 94 was observed lying in bed. She was observed to have a contracture to her left hand. No splint devices were observed on Resident 94. She indicated she should wear a splint at night, but that it had not been applied the night before. On 11/27/18 at 8:25 a.m., Resident 94 was observed lying in bed. She did not have a palm	F 0688	**F688 Increase/Prevent Decrease in ROM/Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #94 is utilizing splinting device per plan of care and MD order and is receiving passive range of motion per plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the	01/02/2019

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	protector on and indicated the staff did not apply it. On 11/27/18 at 3:48 p.m., Resident 94 was observed lying in bed. She was observed to not have a palm protector to the left hand, heel float device to bed, or pillow under her calves. Resident 94 indicated she did not refuse the devices, staff didn't apply them. On 11/28/18 at 12:45 p.m., Resident 94 was observed to be lying in bed. No palm protectors, heel float devices, or pillows under the calf were observed. On 11/27/18 at 3:00 p.m., the record was reviewed for Resident 94. She had diagnoses that included, but were not limited to, hemiplegia, contracture of left hand, and contracture of the right and left knee. A MDS (Minimum Data Set,) dated 10/3/18, indicated Resident 94's cognition was moderately impaired. Resident 94's current physician's orders were reviewed. She had orders for "palm protector, wear left palm protector daily, taking off for hygiene and routine skin checks. Every shift; 6:00 p.m. -6:00 a.m., 6:00 a.m.- 6:00 p.m. with a start date of 1/19/18. Positioning/Devices: heels up device while in bed, special instruction: pillow placement under calf. Every shift; 6:00 p.m.-6:00 a.m., 6:00 a.m.- 6:00 p.m., start date 1/19/18. Heel float device to bed, special instructions: Indication: preventative measure [DX: encounter for other specified aftercare] Every shift; 6:00 p.m., -6:00 a.m., 6:00 a.m.- 6:00 p.m., start date 7/3/18." Resident 94's care plans were reviewed. She had a care plan that indicated resident requires passive range of motion with an approach of passive		potential to be affected by the alleged deficient practice. · All residents who have an order for splints or receive passive range of motion were reviewed to ensure the orders and care plans were followed by DNS/designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All nursing staff will be in-serviced by DNS/designee by 12/28/18 on contracture management policy and appropriate utilization of positioning and splinting devices as indicated on the resident profile and plan of care. · Observational rounds will be completed daily by DNS/designee to ensure that all residents are utilizing devices per plan of care and are receiving passive range of motion per plan of care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of an Range of Motion QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is	

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	range of motion program: resident will tolerate 5 (five) repetitions of passive range of motion to upper and lower extremities. Restorative flow sheets were reviewed for October and November, 2018. The October flow sheet had not been signed by the restorative aide on 10/1, 10/2, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/25, 10/26, 10/28, and 10/28. The November flow sheet had not been signed by the restorative aide on 11/1, 11/2, 11/3, 11/5, 11/7, 11/8, 11/9, 11/12, 11/13, 11/14, 11/15, 11/16, 11/17, 11/18, 11/21, 11/22, 11/23, 11/26, 11/27, 11/28, and 11/ 29. No documentation was observed that the resident refused to wear her positioning devices, or refused restorative services. On 11/28/18 at 4:15 p.m., the Director of Nursing indicated the MDS Coordinator was in charge of the restorative aides. She further indicated the MDS Coordinator should be checking the flow sheets and was responsible to collect them. On 11/29/18 at 2:29 p.m., CNA 9 indicated she thought Resident 94 wore heel protectors, but wasn't sure if wore a splint on her hand. She further indicated she was told restorative took care of it . Resident 94 was observed to not have splint on hand or heel protectors on or pillow under leg in bed at this time. On 12/3/18 at 10:08 a.m., the MDS (Minimum Data Set) Coordinator indicated MDS oversaw the restorative aide, and the MDS assistant made sure the evaluations were done, and that she would need to look at it. ON 12/3/18 at 11:48 a.m., the RN Consultant		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	provided the current policy on the restorative nursing program with a revision date of 11/17. The policy included, but was not limited to, a resident should be placed on a program to maintain the ability to function at his or her optimal level within the given environment. The program was coordinated, supervised, and carried out by nursing staff, preferably the MDS Coordinator or MDS assistant. The CNA would document in Point Click Care, or a monthly flowsheet, the number of minutes the program was (except scheduled toileting programs) and their initial. Restorative nursing program include: active or passive range of motion, splint or brace assistance. 3.1-42(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure a resident with dementia received the appropriate services and treatment to maintain her highest practicable physical, mental, and psychosocial well-being for 1 of 2 residents reviewed for dementia care. (Resident 30) Findings include: During a review of Resident 30's clinical record on 11/28/18 at 7:59 a.m., it indicated Resident 30 was severely cognitively impaired. It further indicated	F 0744	**F744 Treatment/Service for Dementia** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident 30 is now having 1:1 Activity's being offered to her with an update to her preferences for Individualized Activities to her Plan of Care. Resident is encouraged to participate in group activities as resident tolerates.	01/02/2019

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	155224	A. BUILDING 00 B. WING	12/03/2018

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	her diagnoses included, but were not limited to, Diabetes Mellitus, non-Alzheimer's dementia, manic depression, PTSD (Post-Traumatic Stress Disorder), dementia with behavioral disturbance. A review of the care plans indicated the following: Resident is at risk for s/s (signs and symptoms) of depression. Interventions listed included, but were not limited to, encourage activities of interest. Resident is unable to make daily decisions without cues/supervision. Interventions listed included, but were not limited to, avoid assuming an overly protective attitude toward resident, calm resident if signs of distress develop during the decision making process, provide the resident opportunities to make decisions, respect resident rights to make decisions. At times, resident expresses preference of doing most leisure activities in the comfort of her room, requires much encouragement to participate in groups. Interventions listed included, but were not limited to, offer reassurance that she can leave activity when she wants to or come watch from a distance, praising all participation attempts active or passive. Give verbal reminders and escort to activities of interest such as musical entertainment, simple crafts, coloring, social opportunities, lovely nails, provide materials for independent activity use such as magazines, daily chronicles, coloring materials, etc. The following observations were made: 11/26/18 at 3:23 p.m., Resident 30 was walking the hallway, hitting and counting the pictures on the wall. Other residents observed in activities on the		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on the cottage have the potential to be affected by the alleged deficient practice. · All residents on the cottage were reviewed to ensure the residents received the necessary care and services per plan of care. Based on observational rounds, care plans were revised as needed by the IDT team. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · **All staff** will be in-serviced by DNS/designee to highlight the Treatment/Service for Dementia must insure each resident's care needs are met and that quality of life is encouraged through the environment and the delivery of services. · Observational rounds will be conducted daily by IDT/designee to observe staff treatment and promotion of resident overall resident well-being and to ensure care plans are followed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	unit. 11/27/18 at 10:11 a.m., Resident 30 observed sitting in chair in room, talking to self, counting. Other residents observed in community area dancing with staff, listening to music. 11/27/18 at 10:14 a.m., Resident 30 was observed walking in the hall, hitting pictures on wall, counting, carrying purse on shoulder. 11/27/18 at 10:14 a.m., Resident 30 was observed in the hallway. Laundry aide was observed telling Resident 30 to go to her room. Resident 30 was observed to run around and walk back to her room, counting as she went. 11/27/18 at 10:21 a.m., Resident 30 was observed in her room sitting in a chair at bedside, counting. 11/27/18 at 2:43 p.m., Resident 30 was observed in her room, door closed, counting to self. 11/27/18 at 2:53 p.m., Resident 30 observed sitting in her room, door closed, counting to self. Other residents on unit observed in activities playing trivia games. 11/27/18 at 3:00 p.m., Resident 30 observed walking in the hall, hitting the pictures and counting repetitively. CNA 8 observed to run down hall to Resident 30 and direct her back to her room, and shut the door. 11/28/18 at 11:21 a.m., Resident 30 was observed walking in the hallway, counting, hitting pictures on wall, opening and closing other resident doors. 11/28/18 at 11:22 a.m., the Memory Care Facilitator/CNA 1/Activity Director came down		**into place?** · The DNS/designee will be responsible for the completion of an Accommodation of Needs QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	the hallway to Resident 30 and guided her into her room. She then indicated she was going to assist her to the restroom. 11/28/18 at 11:34 a.m., the Memory Care Facilitator/CNA 1/Activity Director was observed to take Resident 30 back to her room from the hallway. She then sat in a chair next to her chair to chat with her. During an interview with Activity Aide on 11/27/18 at 10:17 a.m., she indicated she will do some 1:1 activities or reading with Resident 30 in her room at times, but she was not on a 1:1 calendar. During an interview on 11/27/18 at 10:30 a.m., the Memory Care Facilitator/CNA 1/Activity Director indicated Resident 30 had preferences to not participate in activities or to eat in the main dining room. During an interview on 11/27/18 at 10:37 a.m., LPN 2 indicated Resident 30 did not receive 1:1 activities and eats in her room, per management request. She further indicated she eats 100% of her meals when she eats in her room, and eats much less if in the dining room. She further indicated she stays in her room most of the time, coming out to the hallway to count and hit on the pictures. She indicated 1:1 activities had not been tried with Resident 30, " but, they probably need to." Resident 30 is redirected to her room most of the time because she upsets other residents. Staff does not encourage her in group activities for this reason. During an interview with CNA 8 on 11/28/18 at 11:29 a.m., she indicated staff does try to keep Resident 30 in her room due to keeping her out of			

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	the refrigerator. During a follow-up interview with the Memory Care Facilitator/CNA 1/Activity Director on 12/3/18 at 2:00 p.m., she indicated Resident 30's care plans indicate she should be offered activities of interest, and should not be kept in her room, but should be encouraged to attend activities. She further indicated Resident 30 was not able to make all preferences known, and needed cueing with daily decision making. She further indicated Resident 30 enjoyed getting her nails painted and listening to music, so she would be implementing these as activities on a regular basis. The current facility policy, dated 12/2014, obtained by Nurse Consultant 1 on 12/3/18 at 11:48 a.m., indicated, " ...Insures each resident's care needs are met and that quality of life is encouraged through the environment and the delivery of services by other disciplines at the facility. 3.1-37			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs			

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	and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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 medications were labeled with open dates upon opening in 2 of 3 medication rooms and 2 of 3 medication carts. (Second floor Medication Room, First floor Medication Room, 2400 Medication Cart, 1100 Medication Cart, Resident 85, Resident 23) Findings include: 1. On 11/28/18 at 8:23 a.m., LPN 3 was observed to remove a cup of loose pills in two medication cups from the top drawer of the medication cart with CC written in black on the cup, and one appeared to contain Tums Chewables (medication used to treat indigestion) and hand them to Resident 23, who took them. On 11/28/18 at 8:44 a.m., LPN 3 indicated she set up medications sometimes, and she can't get done with the number of patients and treatments that have to be done. 2. On 11/29/18 at 9:09 a.m., the second floor	F 0761	**F761 Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Licensed nurses are ensuring that medications administered to residents are labelled, dated and are not expired **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by this alleged deficient practice · DNS/Designee will in-service all licensed nurses on the labeling and dating of opened medications · All medication carts and medication rooms were audited to	01/02/2019

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	medication room was observed to have a vial of influenza vaccine which was undated with the seal broken. 3. On 11/29/18 at 9:16 a.m., the 2400 hall cart was observed to have Novolog (medication used to lower blood glucose) flexpen prescribed for Resident 85, with an opened dated of 10/10/18, and a Novolog flexpen prescribed for Resident 85, with an opened date of 9/19/18, located in the medication drawer. On 11/29/18 at 9:21 a.m., MDS Coordinator indicated the insulin pens were good for 30 days from the opened date. 4. On 11/29/18 at 10:17 a.m., the first floor medication room was observed to have a vial of tuberculin serum undated in the refrigerator. 5. On 11/29/18 at 10:22 a.m., the 1100 hall medication cart was observed to have a Levimir (medication to lower blood glucose) flexpen prescribed for Resident 23, with an opened date of 10/7/18. On 11/29/18 at 10:23 a.m., the Director of Nursing indicated the tuberculin serum was good for 30 days after opening and the Levemir flexpen was good for 42 days. It was outdated for Resident 23. On 12/3/18 at 11:48 a.m., RN Consultant 1 provided the current facility policy, Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised 1/1/03. The policy indicated, but was not limited to, "facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."		ensure all medications were labeled with open dates upon opening by DNS/Designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS/designee will facilitate an in-service with all licensed nurses on the proper labeling, dating and expiration of medications · DNS/designee to monitor med rooms, refrigerators, and med carts daily to ensure medications are properly labeled. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of a Medication Storage QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	3.1-25(b)(5)(1) 3.1-25(j)		**Date of Compliance 01/02/2019**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at the proper temperature for 1 of 2 meal observations. 10 of 11 residents indicated the food was cold. (Resident 99, Resident 4, Resident 67, Resident 41, Resident 75, Resident 95, Resident 13, Resident 5, Resident 73, Resident 105, and Resident 99) Findings include: 1. On 11/26/18 at 9:01 a.m., Resident 99 indicated that food is cold by the time it gets passed to the halls. 2. On 11/29/18 at 8:35 a.m., the food cart was observed to be sitting on the 2100 hall. Dietary Aide 3 was observed to start passing trays at 8:45 a.m. The door to the food cart was observed to be left open, and was shut at 8:53 a.m.	F 0804	**F804 Nutritive Value/Appear, Palatable/Prefer Temp** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** ·Staff are ensuring food is served at the appropriate temperature by moving meal service for room trays to the main kitchen and using a heated meal service delivery system. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by this alleged deficient practice	01/02/2019

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	3. On 11/29/18 at 8:56 a.m., the 2200 hall was observed to be served. The door to the food cart was left open. 4. On 11/29/18 at 9:09 a.m., the Dietary Manager indicated the plate warmer was used in the Kitchenette on the second floor, and she had not heard of any complaints about cold food. 5. On 11/30/18 at 8:58 a.m., Resident 99's food temperatures were taken. The eggs were 100 F (Fahrenheit), the orange juice was 60 F. The plate was not hot to touch. 6. On 11/30/18 at 9:10 a.m., Resident Council minutes were reviewed. The minutes for 7/18 and 1/18 indicated residents complained about cold food. 7. During the resident council meeting on 11/28/18 at 3:00 p.m., 10 of 10 residents indicated food was under or overcooked, did not taste good, and was not served at the appropriate temperatures: Resident 4, Resident 67, Resident 41, Resident 75, Resident 95, Resident 13, Resident 5, Resident 73, Resident 105, and Resident 99. The residents usually attended the Resident Council meetings. On 12/3/18 at 11:48 a.m., the RN Nurse Consultant 1 provided the current policy on food temperatures with a revision date of 11/17. The policy included, but was not limited to, Hot foods that are potentially hazardous will leave the kitchen (or steam table) at or above 135 F (Fahrenheit) , and cold foods at or below 41 F. All hot and cold foods items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food.		·CDM/RD/Designee will in-service dietary staff on use of the heated meal service delivery system and proper delivery of trays by . **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·RD/DM/Designee will conduct an in-service with dietary staff to ensure understanding of the policy on food temperatures and temps are maintained while being served. ·A test tray will be sent up on the last cart to monitor that temps are maintained. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Tray line Observation QA will be conducted by the DM/RD/designee 4 times weekly x 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters, results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in the practice will result in re-training and disciplinary action up to and	

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	3.1-21(a)(1) 3.1-21(a)(2)		including termination of responsible employee. ·Test tray temperatures will be completed on cart(s) used for delivery of room service trays by CDM/RD/Designee. **Date of Compliance 01/02/2019**	
F 0812 SS=F 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 1 of 1 meal preparations observed and 3 of 3 kitchen observations. Staff touched food and dishes with	F 0812	**F812 Food Procurement, Store /Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/02/2019

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	bare hands, failed to perform hand hygiene, hair was exposed, and floors and equipment were soiled, and a thermometer was not sanitized. (Kitchen, Kitchenette) Findings include: 1. During the initial tour of the kitchen on 11/26/18 at 8:13 a.m., the floor under and beside the kitchen stove and tilt skillet was observed to have grease, dirt, and food buildup. The front panel of the tilt table was gone, and grease and food build up was observed on the surfaces. The same was observed on 11/28/18 at 12:03 p.m., and on 11/30/18 at 10:30 a.m. 2. On 11/26/18 at 12:53 p.m., in the 2nd floor Kitchenette, Diet Aide 1 was observed to obtain a paper towel, wet it, and lay it on the counter. He was observed to use the same paper towel to wipe the thermometer in between obtaining the temperatures of the food on the steam table. 3. On 11/27/18 at 11:04 a.m., during an observation in the kitchen, Cook 1 was observed to have hair exposed at the sides and back of the head. 4. On 11/27/18 at 11:07 a.m., the Dietary Manager was observed to have hair exposed at the sides and back of the head. 5. On 11/28/18 at 11:11 a.m., Dietary Cook 2 was observed to lay a clean ladle onto a table that had food crumbs on it. The ladle was laid onto the food crumbs. 6. During observation on 11/28/18 at 11:13 a.m., Dietary Cook 1 was observed to puree food for the noon meal. She was observed to have hair		**practice?** ·Dietary staff are wearing the appropriate hair covering, storing utensils on clean surfaces, performing the appropriate hand hygiene and proper handling of food and food service equipment and dishware. ·Environmental maintenance and cleaning completed to identified areas in kitchen. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·In-service for Dietary Staff will be conducted by CDM/RD/Designee on appropriate hair covering, proper storing of equipment, hand hygiene, proper handling of food and food service equipment. ·CEC will in-service staff involved in meal service on proper handling of dishware. ·All floors and equipment were deep cleaned by CDM/Designee on **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed	

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	uncovered on the sides and back of the head. She walked to the dishwasher room, grabbed the clean food processor bowl and blade, walked back to the food prep area, and put the bowl and blade onto the base. She then grabbed a pan of muffins, and sat them on the food prep table. Cook 1 obtained food thickener and placed the measuring cup on the food prep table. She was observed to walk to the refrigerator, obtain a gallon of milk, walk back to the food prep area, and don gloves. No hand hygiene was observed before donning gloves. She then put the muffins into the food processor, took off her gloves, and walked to the dishwasher room to get a clean measuring cup, walked back to the food prep table and put milk into the food processor bowl. She pureed the muffins, and took the food processor bowl and blade to the dishwasher room. She returned to the food prep area and opened a drawer to obtain a scoop. Cook 1 obtained clean pans and carried them to the food prep table, sprayed the pans with cooking spray, and scooped the pureed muffins into the pans. At this time the hair net covering the back of Cook 1's head fell off, and all of the hair gathered at the back of the head was exposed. The Dietary Manager (DM) told Cook 1 her hair net had fallen off. Cook 1 proceeded to go the the hand wash sink and fix her hairnet. She then washed her hands, came back to the food prep area, opened drawers, walked to the dishwasher room, and walked back to the food prep area. She opened a drawer and obtained a spatula. She then scraped the rest of the muffin puree into a pan. 7. During an observation on 11/28/18 at 11:39 a.m., of the puree of the entree and vegetable for the noon meal, Cook 2 was observed to have hair exposed on the sides and back of her head. Cook 2 at 11:39 a.m., was observed to take the dirty food processor bowl and blade to the dishwasher room,		by DM/RD/designee for all staff to include hand hygiene during meal service and proper handling of dishware. ·An in-service will be completed by DM/RD/designee for all dietary staff to include hand hygiene during meal preparation. ·An in-service will be completed by DM/RD/designee for all dietary staff to include identification of environmental/maintenance issues within the department, maintenance work orders process, contact surface cleaning and maintenance. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·CDM/RD/Designee will complete skills validation on handwashing for dietary staff. ·CDM/RD/Designee will complete skills validation on proper use of probe thermometer. ·CEC will complete skills validation for handwashing for all staff involved in meal service. ·Meal manager will observe meal service to ensure food is served in a sanitary manner. ·CDM will observe dietary staff for proper hair covering during meal preparation and meal service. ·CDM/RD/Designee will observe	

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	rinsed the bowl out in the sink, put the processor bowl and blade in a dish rack, and ran it through the dishwasher. She was observed to walk back to the food prep area and put the processor onto the stand. She went to the oven and got tomatoes out, came back to the food prep table, and scooped tomatoes into the food processor. She added thickener and water, opened a drawer, obtained a scoop, and sprayed a pan. Cook 2 pureed the tomatoes and scooped them into the pan. Cook 2 indicated she needed to make more pureed tomatoes and went to the oven to obtain more tomatoes, and carried them to the food prep table. She put the pan of tomatoes back in the oven. She added water and thickener to the tomatoes and pureed them. She put them into a pan. No hand hygiene was observed prior to pureeing either batch of tomatoes. 8. On 11/28/18 at 12:35 p.m., Cook 2 was observed to fill a cart for the Cottage unit with food trays. She was observed to grab blueberry muffins with her bare hands as she was plating the food. She further was observed to touch the plates and bowls with her bare hands on the eating surfaces. 9. On 11/28/18 at 12:14 a.m., the Dietary Manager indicated that the tilt skillet should be cleaned every time it is used, and that she believed a piece was missing from the front of the equipment. Cook 2 indicated it needed cleaned, and she had not had time to clean it. The Dietary Manager further indicated that all hair should be covered, and the floor should be cleaned daily. On 11/28/18 at 12:26 a.m., Cook 2 indicated that hands should be washed every time you walk away from the food prep area.		cleanliness of floor and equipment each day to ensure cleanliness. ·Meal Observation audit will be conducted by ED/department head managers/ designee 4 times weekly x 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ·Tray line audit will be conducted by the DM/RD/designee 4 times weekly x 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters, results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in the practice will result in re-training and disciplinary action up to and including termination of responsible employee. ·A Sanitation Audit will be completed by DM/ED/RD/designee 3 times weekly. From the results of the audit, maintenance requests will	

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	On 12/3/18 at 10:40 a.m., the Dietary Manager indicated that alcohol pads are kept in the upstairs Kitchenette and are to be used to clean the thermometer in between taking the temperatures of the food. 10. On 11/26/18 at at 12:28 p.m., CNA 2 was observed to touch the upper edges of glasses being served to Resident 49, Resident 5, and Resident 65 while serving drinks at that table. 11. On 11/26/18 at 12:35 p.m., CNA 2 was observed to touch the upper edges of glasses while serving Resident 21 and Resident 66. On 12/3/18 at 8:59 a.m., CNA 3 indicated they were to served the glasses from the bottom and demonstrated by picking up a glass from the lower half when moving. 12. During an observation on 11/26/18 at 12:48 p.m., CNA 11 was observed to touch the rims of multiple glasses sitting on a tray for drink service. 13. During an observation on 11/26/18 at 1:15 p.m., CNA 11 blew on her fingers to cool them after touching a hot plate, then served Resident 123 her meal tray. 14. During an observation on 11/26/18 at 1:21 p.m., LPN 1 was observed to serve Resident 177 her meal tray. LPN 1 did not perform hand hygiene prior to or after serving the meal tray. 15. During an observation on 11/26/18 at 1:45 p.m., CNA 3 was observed to serve Resident 98 her meal tray. CNA 3 did not perform hand hygiene prior to or after serving the meal tray. 16. On 11/26/18 at 1:06 p.m., CNA 8 was observed to move Resident 19's chair at the dining room table, obtain the resident's lunch tray from the hall		be completed, proper sanitizing of equipment will be completed. Follow up will be overseen by the ED and DM. Audit trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in cleaning, label/dating and maintenance practices will result in re-training and progressive disciplinary action up to and including termination of responsible employee(s). **Date of Compliance 01/02/2019**	

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	cart, and serve the tray to the resident. CNA 8 was then observed to obtain Resident 82's tray from the hall cart and serve the resident. No hand hygiene was observed. On 11/29/18 at 9:00 a.m., the Dietary Manager provided the current policy on Dietary Personal Hygiene, with a revision date of 7/15. The policy included, but was not limited to,"Dietary employees must wash their hands before they start work and after, before putting on gloves and after removing them, and before touching anything else that may contaminated hands, such as unsanitized equipment, work surfaces, or washcloths. The policy further indicated staff should wear a clean hat and/or other hair restraint, and to wash and rinse fixed food - contact surfaces, then wipe with a chemical sanitizing solution." On 11/29/18 at 9:00 a.m., the Dietary Manager provided the current policy on cleaning and sanitizing equipment with a revision date of 7/15. The policy included, but was not limited to, "dietary staff will maintain clean and sanitized equipment, and remove food and soil from under and around the equipment." On 12/3/18 at 11:48 a.m., the RN Nurse Consultant 1 provided the current policy on sanitation of the kitchen, with a revision date of 7/15. The policy included, but was not limited to, "the dietary staff will maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule. The cleaning schedule was reviewed. The schedule indicated, but was not limited to, the PM cook is to sweep and mop after each meal, from aide prep table to dish room, grease trap under range, both drip pans should be checked and initiated daily. AM			

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	cook sweep mop after each meal, from aide prep table to dish room." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E 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 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;			

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	(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 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	F 0880	**F880 Infection Prevention and Control**	01/02/2019

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	interview, the facility failed to ensure proper hand hygiene and glove use during care for 5 of 10 residents observed for care. Staff failed to properly handle dirty linens, and failed to perform hand hygiene prior to and after providing care. (Resident 323, Resident 72, Resident 90, Resident 118, Resident 10) Findings include: 1. During an observation on 11/29/18 at 8:49 a.m., CNA 12 was observed to enter the shower room, don gloves without performing hand hygiene, and grab a Microkill microbial wipe to clean off the shower chair. She then gathered dirty linens from the floor and placed them into a soiled hamper, leaving the lid of the hamper open. CNA 12 was not observed to disinfect the shower head or shower floor. She then removed her gloves and left the shower room. No hand hygiene was observed. CNA 12 was observed to assist Resident 323 to the shower room. Resident 323 removed her clothes and stepped into the shower. CNA 12 donned gloves without performing hand hygiene and handed Resident 323 a clean washcloth. Resident 323 was observed to perform her shower independently with CNA 12 standing at her side. CNA 12 handed Resident 323 her shampoo, soap, and clean linens. CNA 12 never removed or changed her gloves, and was not observed to perform hand hygiene during the shower process. Resident 323 dried off with a clean towel, provided by CNA 12. She then dressed independently with the clothing handed to her by CNA 12. CNA 12 was still observed to be wearing the same gloves. CNA 12 then handed Resident 323 her shoes. CNA 12 was observed to remove her gloves and don new gloves. She then proceeded to use		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Showers are being provided following proper infection control practice regarding handwashing, gloving, and properly handling of dirty linens for Residents 323, 72, 90, 118, and 10. · The shower room was cleaned using a disinfectant spray. · In-service was provided to all staff regarding proper infection control practice handwashing, gloving, and disinfecting equipment. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that utilize the common shower room have the potential to be affected by the alleged deficient practice. · All residents that require daily glucose monitoring have the potential to be affected by the alleged deficient practice. · All residents that require assistance with peri-care have the potential to be affected by the alleged deficient practice. · Skills validations for showering a resident and proper peri-care was completed by DNS/designee for all nursing staff.	

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	Microkill wipes to wipe down the shower head and shower chair. She then used a dirty towel to wipe up the floor. No disinfectant was used to sanitize the floor. CNA 12 removed her gloves and left the shower room without performing hand hygiene. 2. During an observation on 11/29/18 at 9:10 a.m., CNA 12 was observed to enter Resident 72's room. CNA 12 was observed to grab clothing out of the closet. She then left Resident 72's room to grab socks from laundry. Upon reentering Resident 72's room, CNA 12 was observed to assist Resident 72 into his wheelchair, and then grab his shoes out of his closet. No hand hygiene was observed. CNA 12 left the room to place Resident 72's hygiene items into the shower room. She returned, and assisted Resident 72 to the shower room. CNA 12 donned gloves without performing hand hygiene. She then placed a clean towel on the floor in front of the shower chair, and assisted Resident 72 out of his wheelchair, pulled down his pants, and removed his brief. She then held the soiled brief in her left gloved hand as she assisted Resident 72 into the shower chair, touching the shower chair arm as she did so with the soiled brief. She then tossed the soiled brief into the trash bin. CNA 12 then grabbed Resident 72's clean socks and tossed them into a bin near the shower. She then moved the wheelchair with her gloved hands out of the shower area. CNA 12 grabbed a clean towel with the same gloved hands and placed it under Resident 72's feet, removing his pants and socks. Again, using the same gloves, tossed the dirty linen items into the soiled hamper, returned and removed Resident 72's shirt, and tossed it into the soiled hamper. CNA 12 was not observed to remove her gloves or perform hand hygiene. She removed Resident 72's watch and turned on the shower water. CNA 12 handed		· Skills validations for proper disinfecting of glucometers was completed by DNS/designee for all licensed nursing staff **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by DNS/designee for all staff to include regarding proper infection control practice of handwashing, gloving, disinfecting equipment and proper handling of soiled linen. · Observational rounds will be completed daily by DNS/designee to ensure that proper infection control practice regarding handwashing, gloving, and disinfecting equipment are followed by staff during showers. · Observational rounds will be completed daily by DNS/designee to ensure that proper infection control practice regarding peri-care.\ · Observational rounds will be completed daily by DNS/designee to ensure that proper infection control practice regarding disinfecting of glucometer. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Resident 72 a clean cloth to place over his eyes as she wet and shampooed his hair. CNA 12 shampooed Resident 72's hair with the same gloves, running her fingers through his hair. She then used a clean washcloth to wash his back, underarms, arms, chest and stomach, legs, and feet. CNA 12 never changed washcloths. She then tossed the dirty cloth into the soiled hamper. She obtained a clean cloth and handed it to Resident 72 to wash his periarea. She then washed his buttocks with a clean cloth. CNA 12 was still wearing the same gloves. CNA 12 then obtained the shower head and rinsed Resident 72, making sure to use her gloved hands to spread his toes. She then grabbed a clean towel and placed it around Resident 72's shoulders, and grabbed a second towel to dry his legs and feet. CNA 12 then applied Resident 72's socks with her same gloved hands. CNA 12 then assisted Resident 72 in putting on his brief and clothing with the same gloved hands. She then gathered the dirty linens and tossed them into the soiled hamper. CNA 12 removed her gloves, but did not perform hand hygiene. She then assisted Resident 72 into his wheelchair and back into his room. CNA 12 returned to the shower room and donned gloves without performing hand hygiene. She then used a Microkill wipe to wipe off the shower chair. She used a dirty linen to wipe up the shower floor, no disinfectant was observed to be used on the floor. During an interview with CNA 12 on 11/29/18 at 9:30 a.m., she indicated the shower room did not have soap in the soap dispenser. She indicated new soap had been ordered, but did not fit in the dispenser. She was having to perform hand hygiene in resident rooms, and knew she should be washing prior to and after assisting residents. She further indicated staff never disinfected the shower floor. She did not even know if they had		· The DNS/designee will be responsible for the completion of Infection Control QA Tool and skills validation for glucometer disinfection weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	disinfectant to do so, but felt that it should be getting done. 3. On 11/27/18 at 10:40 a.m., CNA 3 was observed to provide care for Resident 90. CNA 3 gathered washcloths and supplies. CNA 3 shut the curtain and donned gloves, wet the washcloths, looked for a brief in the closet, then removed her gloves and left the room without performing hand hygiene. CNA 3 returned with briefs and donned gloves, without performing hand hygiene. She then rewarmed the washcloths in the bathroom. CNA 3 proceeded to perform pericare to Resident 90's groin, rinsed with a separate cloth, rolled the resident to his side, utilized the same washcloths to wash and rinse Resident 90's buttocks, completed care, and washed her hands. 4. On 11/27/18 a 11:05 a.m., QMA 1 was observed to clean the glucometer, wetting all surfaces approximate 30 seconds, changed her gloves, sanitized her hands, and sat the glucometer on the back of the cart. On 11/27/18 at 11:06 a.m., QMA 1 indicated she was to use a bleach wipe and wait 3 minutes before she could use the glucometer again. On 12/3/18 at 11:48 a.m., the RN Consultant 1 provided the current facility procedure, Glucose Meter Cleaning & Testing, review date 1/2016. The Procedure indicated, but was not limited to, obtain single use germicidal wipe. Wipe entire eternal surface of the blood glucose meter with wipe for 3 minutes. Place cleaned meter on paper towel, in plastic cup or clean barrier. Allow meter to completely dry. 5. On 11/29/18 at 9:30 a.m., CNA 4 was observed to provide personal care for Resident 10. When			

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	cleansing the groin area for Resident 10, CNA 4 was observed to cleanse brown matter from the right groin, wiping from back to front on sides, and the middle of her peri area. CNA 4 removed his gloves, left the room without hand hygiene, to obtain more washcloths from the linen closet. CNA 4 reentered the room, no hand hygiene was performed, wet washcloths, and wiped front to back till no residual brown matter remained. A disposable pad was flayed out on the bed, and the soiled pad was pulled out from underneath Resident 10 and dropped on the floor. CNA 4 proceeded to wash Resident 10's face and mouth, removed his gloves and dropped them on the disposable pad on the floor. CNA 4 applied gloves, without hand hygiene, and picked up the items on the floor and placed them in a plastic bag, and tied it shut. When CNA 4 removed his gloves, he washed his hands thoroughly. On 12/3/18 at 11:48 a.m., RN Consultant 1 provided the current facility procedure, Perineal Care, review date 3/2012. The Procedure indicated, but was not limited to, separate the labia and wash the urethra first. Wash between and outside labia in downward strokes. Alternate from side to side - wipe from front to back and from center of perineum outward. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the washcloth. Change washcloth as needed. 6. On 11/27/18 at 10:57 a.m., incontinence care was observed for Resident 118. CNA 5 was observed to enter Resident 118's room. She was then observed to don a gown and gloves and set up bags at the end of Resident 118's bed. She went to the bathroom, wet and soaped washcloths, came out of the bathroom, and went to Resident 118's bedside. She was observed to			

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	take Resident 118's dirty brief off, and proceed to wash her labia. She put the dirty washcloth into the bag, used a wet washcloth to wipe the soap off of the labia, and used a clean towel to dry the area. She put the used cloths in the bag, rolled the resident to her side, took off her gloves, and donned new ones, went to the bathroom and wet a clean towel and come back to the bedside and wiped Resident 118's buttocks. The resident urinated on the towel while CNA 5 was wiping the buttocks. CNA 5 took off her gloves and donned new ones. CNA 5 put a clean brief under Resident 118. Resident 118 urinated on the clean brief and CNA 5 put the dirty brief into the bag, put a clean draw sheet under the resident , took off her gloves went to the closet and got a new brief, donned new gloves, and rolled the resident onto her side. CNA 5 put the dirty chuck in the bag, and put the clean brief under Resident 118 and sprayed barrier spray on the residents genitals and buttocks. She then fastened the brief, put the dirty linens in a bag, took off her gloves and put into the bag and tied the bag and donned new gloves. No hand hygiene was performed between changing gloves or during care. On 11/27/18 at 11:12 a.m., CNA 6 was observed to walk into Resident 118's room and don gloves, she was then observed to go to the doorway and obtain a gown and don it. No hand hygiene was observed when entering the room or before donning gloves and gown. On 11/30/18 at 3:00 p.m., Nurses Aide 1 indicated if a resident is on contact isolation, there is usually a cart outside of the resident's room. She further indicated staff are supposed to gown up and wash hands before entering the room, wash hands and change gloves during care when going			

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	from clean to dirty, and wash hands before leaving the room. During a review of the current policy, " Hand Hygiene Policy," revised 3/2018, on 12/3/18 at 11:48 a.m., it indicated, "...5 moments of hand hygiene...before touching a patient, before lean/aseptic procedure, after body fluid exposure risk, after touching a patient, after touching patient surroundings. 3.1-18(b) 3.1-18(l)			
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, interview, and record review, the facility failed to provide a safe and sanitary environment for 4 of 7 rooms reviewed. Floors were sticky and stained, tape was hanging on the side of the commode, doors were scraped, odors were present, and tables were soiled. (Room 1306, Room 1208, Room 1101, Conference Room) 1. On 11/26/18 at 11:42 a.m., Room 1306 was observed with a piece of cellophane tape hanging off the side of the commode, the bathroom floor was sticky, the commode had urine in it, and the room entry door had wood scraped off. On 11/28/18 at 10:60 a.m., the cellophane tape was still hanging on the side of the commode and the entry door had wood scraped off.	F 0921	**F921 Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Rooms 1306, 1208, 1101 were deep-cleaned, floors thoroughly mopped, doors repainted, tables cleaned with the appropriate disinfectant. · The conference room was not in use and is currently under renovation. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	01/02/2019

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	On 12/3/18 at 1:26 p.m., Housekeeper 1 indicated she dusted the woodwork daily, cleaned the walls if she saw anything on it, mopped the floor in the resident's rooms and bathrooms, and emptied the trash. She indicated she often will do the resident's rooms and bathrooms in the morning and recheck the rooms in the afternoon prior to leaving the facility. 2. During an observation on 11/26/18 at 4:23 p.m., the commode in Room 1208 was dirty around the rim and a dead bug was observed on the wall. On 11/29/18 at 12:11 p.m., the same was observed. 3. During an observation on 11/26/18 at 9:48 a.m., Room 1101 had a urine odor. On 11/29/18 at 12:00 p.m., the same was observed. 4. During an observation on 12/3/18 at 10:26 a.m., the downstairs conference room was observed to have a huge black stain on the carpet, the conference table chairs were dusty and dirty, and a spill was noted on the conference table leg. The room had a sign on the door indicating, "No Entry." During an interview with the Housekeeping Supervisor on 12/3/18 at 10:30 a.m., he indicated all carpets had been shampooed and the chairs did need to be cleaned or thrown out. A review of the current cleaning schedules on 12/3/18 at 11:48 a.m., indicated all rooms are deep cleaned on a rotating calendar, all dining rooms are deep cleaned on Sundays and all shower rooms were deep cleaned on Saturdays. During a review of the current policy, " Housekeeping," undated, on 12/3/18 at 11:48 a.m., it indicated, " To ensure a clean, safe and sanitary environment to prevent the spread of		**corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · An in-service will be completed by ED/Designee for all housekeeping staff to include deep clean schedule, daily cleaning responsibilities and the appropriate use of disinfectant spray between resident's use of shared bathrooms. · An audit of all room was conducted to observe for cleanliness of floors, cleanliness of commodes, to ensure doors were in good repair and to ensure there were no odors. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by ED/Designee for all housekeeping staff to include deep clean schedule, daily cleaning responsibilities and the appropriate use of disinfectant spray between resident's use of shared bathrooms · Observational rounds will be completed by ED/designee daily to ensure that staff are appropriately cleaning resident rooms. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	infections...Use proper cleaning methods...use proper dilutions of cleaning products...stock and maintain soap and towel dispensers..remove dust and soil by routine cleaning procedures...perform routine regular cleaning. This Federal tag relates to Complaint IN00280522. 3.1-19(f)		**assurance program will be put into place?** · The ED/designee will be responsible for the completion of the Environmental Rounds CQI Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	
F 9999 Bldg. 00	1. 3.1-13 ADMINISTRATION and MANAGEMENT (w) In facilities that re required under I 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents,	F 9999	**F9999Administration and Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · C.N.A. number 3 no longer works for the facility. **How will you identify other residents having the potential to be affected by the same**	01/02/2019

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	or both, within the past 5 (five) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the locked special dementia care unit had a Memory Care Director for the unit for 4 of 5 days of the survey. Findings include: On 11/26/18 at 9:05 a.m., Auguste's Cottage (a locked special dementia care unit) was observed to have an LPN (Licensed Practical Nurse), 2 (two) CNAs (Certified Nurse Aide), an activity staff person, and a Dementia Care Director on the memory care unit. On 11/26/18 at 9:05 a.m., LPN 1 indicated the Dementia Care Director had been a CNA with the facility but had taken over the facilitator position and the previous facilitator had returned to a CNA position. On 11/27/18 at 10:10 a.m., Auguste's Cottage (a locked special dementia care unit) was observed to have an LPN, 2 (two) CNAs, an activity staff		**deficient practice and what corrective action will be taken?** · All residents have the potential to be affected. · An audit of all C.N.A. records was completed to ensure CNAs were certified within 120 days of employment by CEC/Designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by the ED for all professional nursing staff to ensure all new NAs hired receive their certification within 120 days of hire. · A tracking system will be developed to ensure all NAs who work more than 120 days from employment receive their certification or are removed from C.N.A. duties. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CEC/designee will be responsible for the completion of the C.N.A. QA tool weekly times 4 weeks, monthly times 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results	

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	person, and a Dementia Care Director on the memory care unit. On 11/27/18 at 3:10 p.m., the Administrator indicated the Dementia Care Director did not have a college degree and was a CNA. On 11/28/18 at 8:18 a.m., Auguste's Cottage was observed to have an LPN, 3 (three) CNAs, an activity staff person, and a Dementia Care Director on the unit. On 11/29/18 at 8:30 a.m., Auguste's Cottage was observed to have an LPN, 2 CNAs, an activity staff person, and a Dementia Care Director on the unit. On 11/29/18 at 2:10 p.m., Nurse Consultant 2 indicated the Social Service Designee was the Dementia Care Director for the unit. The SSD had a degree in Health Sciences. On 12/3/18 at 10:13 a.m., LPN 1 indicated the Social Service Designee very rarely came into the unit, except when working on MDS assessments. The current facility policy, dated 12/2014, and obtained from the RN Nurse Consultant 1 on 12/3/18 at 11:48 a.m., indicated a Bachelor's degree was required for the position of Memory Care Program Facilitator. 2. 3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.		of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **Date of Compliance 01/02/2019**	

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	(b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual: (1) is competent to provide nursing and nursing-related services; and (2) has completed a: (A) training and competency evaluation program; or (B) competency evaluation program; approved by the division. (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This State rule is not met, as evidenced by: Based on record review and interview, the facility failed to ensure a CNA (Certified Nurse Aide) was certified in the state of Indiana within 120 days of employment. (CNA 3) Findings include: During a review of the employment records on 12/3/18 at 10:00 a.m., the record for CNA 3 was reviewed. CNA 3's hire date was 7/31/18. The record lacked documentation of an Indiana certification for CNA 3. During an interview with the Payroll clerk on 12/3/18 at 10:10 a.m., she indicated CNA 3 had an active Kentucky certification, and would be getting an Indiana certification. She thought she had 180 days to do so. During an interview with the Central Supply employee on 12/3/18 at 10:30 a.m., she indicated CNA 3 was out of compliance with her			

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	certification and had been taken off the floor and moved to activities until she received her Indiana certification. During a review of the current policy, " License/Certification Tracking and Verification," revised 11/16, it indicated, " A current copy and verification of all license/certification/other must be obtained prior to an employee's start date....It is the responsibility of the employee to maintain a current valid license/certification...The following steps are required to certify an out of state certified nurse aide: Check for good standing of the candidate in the out of state registry for all states where the candidate was certified.			