STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	02/12/2020

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 5, 6, 7, 10, 11 and 12, 2020. Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 6 Medicaid: 64 Other: 8 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 17, 2020.	F 0000	February 28, 2020 ISDH ATT: Brenda Buroker Director Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 CCN/Provider Number 155222 AIM Number: 100291430 Facility ID: 000127 Re:Annual Survey Kokomo Healthcare Center 429 West Lincoln Road Kokomo, Indiana 46902 Dear Ms Buroker, On February 12, 2020 a survey team from the Indiana State department of Health completed our Annual Re-certification Survey at Kokomo Healthcare. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for those alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our formal request for a desk review that the facility has achieved substantial compliance with the	

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

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			applicable requirements as of the date set forth in the Plan of Correction of March 13, 2020 Please feel free to call me with any further questions at (765) 453-5600. Respectfully submitted. Tammy Tinsley, Executive Director	
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.			

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	At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure a bed hold policy was provided to a resident on admission and again during a hospital transfer for 1 of 1 resident reviewed for hospitalization (Resident 44). Finding includes: The record for Resident 44 was reviewed on 02/11/2020 at 9:59 a.m. Diagnoses included, but were not limited to, anxiety disorder, vascular dementia with a behavioral disturbance, major depressive disorder and schizophrenia. A Social Services note, dated 01/29/2020 at 8:09 a.m., indicated the resident was discharged to a psychiatric hospital on 01/28/2020. A copy of the transfer/discharge paperwork which included a copy of the bed hold policy was not located in Resident 44's medical record. An "Admissions Agreement" which was requested during the entrance conference was reviewed and did not contain information related to the bed hold policy. During an interview, on 02/11/20 at 1:16 p.m., the Social Service Director indicated a transfer/discharge form, a medication list, a face sheet and the resident's code status was the information given to the resident and receiving facility when a resident was transferred. A bed hold policy was not given to the resident. A copy	F 0625	F 625 D Notice of Bed Hold Policy The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 44 has returned to the facility. 2) How the facility identified other residents: Director of Nursing will contact any resident and /or representative that is currently hospitalized of the facility bed hold policy/ authorization of document on the bed hold authorization form	03/13/2020

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	of what was sent or given to the resident was not kept in the resident's medical record. A current facility policy, titled "Bed Hold Policy," dated effective 02/17/17 and received from the Unit Manager on 02/11/2020 at 3:27 p.m., indicated "...In the event a resident returns to the hospital or goes on a leave, the following process will be followed by the facility: a. The Admissions Director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. b. The nurse or designee will obtain the residents or responsible party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the Business Office Manager or designee...d. The business office manager or designee will follow all state specific guidelines upon resident return...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26)		3) Measures put into place/ System changes: Director of Social Services will re-educate the licensed nursing staff and admission Department on the Bed Hold Policy 4) How the corrective actions will be monitored: Reviews of up to 5 residents who were transferred to the hospital to ensure the bed hold authorization form was signed prior to the resident leaving the building or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or holiday will be conducted for 5 residents by the Director of Social Services/or designee 2 times per week for 8 weeks, then monthly times 4 months to ensure compliance. Auditing will include all shifts. The results of the audits will be reported to QAPI for 6 months for review and analysis, thereafter the committee will make recommendations for changes for this plan of correction 5) Date of compliance: 3-13-2020	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the			

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	resident's status. Based on observation, interview and record review, the facility failed to accurately assess and document the dental status on the Minimum Data Set (MDS) Assessment for 1 of 9 residents reviewed for dental (Resident 39). Finding includes: During an observation, on 2/6/2020 at 4:10 p.m., Resident 39 was observed to have jagged teeth and lots of food or plaque build up on her teeth. The record for Resident 39 was reviewed on 2/7/2020 at 4:42 p.m. Diagnoses included, but were not limited to, cerebral palsy, type 2 diabetes mellitus, contracture of the right hand and dysphagia (difficulty swallowing). A care plan, revised on 1/4/18, indicated the resident was at risk for oral/dental health problems related to having a broken front tooth. An Annual MDS assessment, dated 12/16/19, indicated the resident did not have an obvious or likely cavity or broken natural teeth. During an interview, on 2/12/2020 at 10: 22 a.m., the Social Services Director (SSD) indicated the resident had a broken front tooth. During an interview, on 2/11/2020 at 1:22 p.m., the MDS Coordinator indicated she did not do an oral assessment when she completed the MDS for the resident's oral condition. She looked at the chart and did not look at the care plans. She did not code the MDS assessment correctly as the resident had a broken front tooth. A current policy, titled "MDS Responsibilities,"	F 0641	**F 641 D Accuracy of Assessments** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** Resident 39 MDS was modified to accurately reflect resident's oral status. **How the facility identified other residents:** Regional MDS will audit current residents for accuracy of assessments in the area of oral status **Measures put into place/ System changes:** In-service completed for MDS with regards to accuracy of MDS. MDS will follow the RAI Guidelines for completion of MDS" **How the corrective actions will be monitored:** Regional MDS will complete a full audit of 4MDS' per month to	03/13/2020

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	revised on 11/15/2019 and received from the Executive Director on 2/12/2020 at 10:10 a.m., indicated "...The interdisciplinary assessment shall be completed for all resident[s] utilizing the Resident Assessment Instrument [RAI]-Minimum data set 3.0...based upon oral or written communication, resident, family interview and assessments provided by the IDT[interdisciplinary]team members...." 3.1-31(c)(9)		validate accuracy. MDS will review the results of these audits in QAPI meeting monthly times 6 months **Date of compliance: 3-13-2020**	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to have a PASARR (preadmission screening and resident review assessment) completed for a resident with a new mental health diagnosis for 1 of 3 residents reviewed for PASARR (Resident 52).	F 0644	**F 644 D PASARR and Assessments** **The facility requests paper compliance for this citation.**	03/13/2020

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	Finding includes: The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, morbid obesity and major depressive disorder. A PASARR Level I, completed on 6/6/19, indicated the resident had no mental health diagnosis known or suspected. A psychiatrist note, dated 11/25/19, indicated the resident had depression and anxiety. The staff was to continue to monitor for mood and behavior changes. A care plan, dated 12/31/19, indicated the resident was at risk for chronic pain related to immobility, carious teeth and depression. Interventions included, but were not limited to, monitor and record mood and behavior changes such as being more irritable, restless and aggressive. During an interview, on 2/7/2020 at 4:10 p.m., the Executive Director indicated the resident should have had a PASARR level I completed when the facility added the diagnosis of the major depressive disorder. She indicated the facility did not have a policy for PASARR. 3.1-16(d)(1)(A)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 52 PASARR was completed. **2) How the facility identified other residents:** Social Services/designee completed a full house audit of all individuals with Level 11 recommendations to assure completion. Any issue identified was immediately corrected **3) Measures put into place/ System changes:** In-service for Social Services Department on the procedures for Level 1 / Level 11 recommendations completion. Social Services will follow up on Level 11 recommendations as requested.	

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			4) How the corrective actions will be monitored: The responsible party for this plan of correction is Social Services with Administrator oversight. Social Services will complete an audit with all new admission/updates to ensure all Level 11 recommendation follow up is completed. Social Services/Designee will review results of PASARR audit in QAPI meeting monthly times 6 months. **5) Date of compliance:** **3-13-2020**	
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			

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	plan. (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 observation, interview and record review, the facility failed to address the use of soft hand splints, resident specific activities of choice and dental needs for 2 of 18 residents reviewed for comprehensive care plan revisions (Resident 31 and 53). Findings include: 1. The record for Resident 31 was reviewed on 02/10/20 at 10:56 a.m. Diagnoses included, but were not limited to, quadriplegia (paralysis of arms, legs and torso), epilepsy (seizure disorder), contracture's of the right and left hands and spasmodic torticollis. During an observation, on 02/10/20 at 10:05 a.m., Resident 31 was in bed, awake, with the television on. Both hands were contracted and curled inward. No splint or hand rolls were in place. There were soft hand splints sitting on the chair next to her bed. During an interview, on 02/10/20 at 10:09 a.m., LPN 3 indicated the resident had soft splints, but she was irritated when they put them on her. During an observation, on 02/10/20 at 10:14 a.m., OT 4 came in to apply the bilateral hand splints and no facial grimacing was noted. Resident 31 smiled.	F 0657	**F 657D Care Plan Timing and Revision** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident's 31 and 52 care plans have been reviewed and revised.** **2) How the facility identified other residents:** **Full house audit completed to assure residents have**	03/13/2020

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	A physician's order, effective 10/21/19, indicated the resident was to wear both hand splints 4-8 hours a day per patient's tolerance based on her facial expressions. Nursing was to monitor the patient for redness, splint comfort, edema and notify therapy. A care plan, dated 3/30/2014, indicated the resident had an activity of daily living (ADL) self care performance deficit related to the left and right hand contractures. The interventions included, but were not limited to, apply splints as ordered to BUE dated 2/23/18 and to assist the resident with ADL's. There were no revisions made to the care plan since 2/23/18. 2. The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, morbid obesity and major depressive disorder. A care plan, dated 12/31/19 , indicated the resident was at a risk for chronic pain related to carious (decayed) teeth. The interventions included, but were not limited to, administer analgesia as ordered, anticipate the need for pain relief and respond immediately to any complaints of pain and to monitor for signs and symptoms of nonverbal pain. A care plan, dated 12/31/19, indicated the resident had oral/dental health problems related to poor oral hygiene. The interventions included, but were not limited to, coordinate the arrangements for dental care and transportation as needed. The care plan did not include the resident was to have a full mouth extraction of his teeth.		**individualized Comprehensive care plans in place.** **3) Measures put into place/ System changes:** **Education provided to nursing staff and IDT on the care plan process.** **4) How the corrective actions will be monitored:** **IDT will review 2 care plans weekly to determine review and revisions have been completed.** **The Director of Nursing/ Designee will review Care Plan Reviews during monthly QAPI times 6 months the quarterly thereafter. The QA committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed.** **5) Date of compliance:** **3-13-2020**	

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	During an interview, on 2/11/202 at 1:29 p.m., the Social Services Director (SSD) indicated the resident wanted IV sedation to have his teeth pulled and she was trying to locate an oral surgeon. She had not updated the resident's care plan. 3. During an interview, on 2/5/2020 at 1:45 p.m., the resident indicated he used to play euchre. During an interview, on 2/12/2020 at 10:34 a.m., the Physical Therapy Manager indicated the resident used to like to play euchre. A care plan, dated 9/5/19, indicated the resident attended activities of choice and engaged in self-initiated activities. The interventions included, but were not limited to, invite, encourage and assist as needed to activities of choice and provide an activity calendar in the resident's room. The care plan did not specify the resident's activities of choice such as playing euchre. During an interview, on 2/11/2020 at 3:18 p.m, the Executive Director (ED) indicated the resident liked to play euchre and the facility had added more euchre tournaments. The care plan should have been updated to include the resident liked to play cards. A current policy, titled " Plan of Care Overview," revised on 7/26/18 and received from the ED on 2/12/2020 at 5:00 p.m., indicated "...for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care...provide guidance to the facility to support the inclusion of the resident or resident			

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	representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines...The facility will...Review care plans quarterly and/or with significant changes in care...Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants...." 3.1-35(c)(2)(B)			
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.			

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	(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 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			

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	155222	A. BUILDING 00 B. WING	02/12/2020

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	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 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on observation, interview and record review, the facility failed to re-evaluate and document the resident's discharge planning for 1 of 2 residents reviewed for discharge (Resident 52). Finding includes: During an interview, on 2/5/2020 at 1:45 p.m., the resident was very irritable and indicated he was getting kicked out of the facility. He indicated he did not want to be discharged and did not know where he would go after he was discharged. The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, morbid obesity and major depressive disorder. A progress note, dated 6/21/19 at 1:36 p.m., indicated the resident was homeless and was admitted to the facility from the hospital for therapy. A progress note, dated 9/5/19 at 10:16 a.m.,	F 0660	**F 660D Discharge Planning** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Ca Care plan was developed that included discharge plan goals for	03/13/2020

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	indicated discharge planning was reviewed with the resident and he stated he wanted to stay at the facility for long term care since he was unable to walk. A progress note, dated 9/18/19 at 2:28 p.m., indicated the resident was at the facility for rehab to home. The resident indicated he was concerned he would need to stay at the facility for long term care. A care plan, dated 7/16/19, indicated the resident was at the facility for a short term rehabilitation stay and would be discharged to the community after rehabilitation and nursing needs were met. The community discharge plan was uncertain. The interventions included, but were not limited to, have all other needed support services in place prior to discharge. The care plan had not been updated since 7/16/19. A Social Services progress note, dated 1/31/2020 at 3:46 p.m., indicated the resident was issued a 30 day notice and would need to be transferred or discharged. The appeal process was explained. The note did not include if the SSD (Social Service Director) had reviewed any alternate placement for the resident. During an interview, on 2/12/2020 at 10:33 a.m., the SSD indicated the resident's record and the care plan did not show the resident's discharge plans had changed and the resident needed long term care. The record did not include documentation of the steps completed to assist the resident with long term care placement or his long term care needs.		resident 52. Care plan meeting held to review discharge plans. **2) How the facility identified other residents:** Fac Audit was conducted to determine active residents had discharge plans and goals developed. Any issue identified was addressed **Me Measures put into place/ System changes** Education provided to the IDT on the components of F660, Discharge planning process.The facility will update residents comprehensive care plan and discharge plan as appropriate. **4) How the corrective actions will be monitored:** Responsible party for this plan of correction is the Director of Nursing/designee who will oversee the audit of 2 residents weekly for the ongoing process of care plan meetings and discharge planning. Audits will be reported to QAPI for 6 months The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance:** **3-13-2020**	

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	A current policy, titled "Transfer and Discharge Policy," dated 3/10/17 and received from the Executive Director on 2/12/2020 at 4:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents, including a smooth transition of care for discharge or transfer....When a resident's discharge is anticipated, facility will develop and implement a discharge plan 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...Discharge Plan...The discharge needs of each resident will be identified and result in the development of a discharge plan for each resident...The discharge plan will...include regular re-evaluation of residents to identify changes that require modification of the discharge plan...The discharge plan will be updated, as needed, to reflect these changes...Involve the interdisciplinary team in the ongoing process of developing the discharge plan...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...Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan...Discharge to Community...Facility will document that a resident has been asked about their interest in receiving information regarding returning to the community...If the resident indicates an interest in returning to the community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose...If discharge to the			

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	community is determined to not be feasible, the facility will document who made the determination and why...." 3.1-36(a)(3)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿ §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals			

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	and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview and record review, the facility failed to identify the cause of a decrease in independent mobility and to identify goals for a return to the prior level of functioning for 1 of 4 residents reviewed for (ADL) activities of daily living (Resident 52). Finding includes: During an interview, on 2/5/2020 at 1:45 p.m., Resident 52 indicated he used to get up, in his wheelchair, all the time and he was not able to get into the chair anymore. He spent most of his time in bed and he ate his meals in his room. He had trouble with his leg after a fracture. During an observation, on 2/5/2020 at 1:53 p.m., the resident was lying in his bed, his legs were turned out. During an observation, on 2/6/2020 at 3:15 p.m., the resident was lying in bed. During an observation, on 2/11/2020 at 9:44 a.m., the resident was lying in bed, in his room, the room was darkened and his legs were spread out with a pillow in between them. The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, weakness, difficulty in walking, heart failure, morbid obesity and major depressive disorder.	F 0676	**F 676 D Activities of Daily Living** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 52 was evaluated for therapy. Restorative programs were reviewed and revised. Care plans updated to reflect current ADL status. **2) How the facility identified other residents:** Any resident had the potential to have been affected.	03/13/2020

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	The diagnoses did not include problems with his ankles, a history of compression fractures or a history of knee or leg fractures. A physician's order, dated 6/19/19, indicated the resident had good rehabilitation potential. A Physical Therapy Evaluation and Plan of Treatment, dated 6/20/19, indicated the resident demonstrated good rehabilitation potential as evidenced by a high prior level of functioning. The short term goal included the resident would safely perform functional transfers with stand by assistance in order to return to the prior level of functional abilities. A progress note, dated 9/5/19 at 10:16 a.m., indicated discharge planning was reviewed with the resident and he stated he wanted to stay at the facility for long term care since he was unable to walk. A Physical Therapy progress note, dated 8/21/19, indicated the resident had moderate to minimal assist with the sliding board transfer from the edge of the bed to the wheelchair. A Physical Therapy progress note, dated 8/27/19, indicated the resident required moderate to minimal assist with the sliding board transfer into his wheelchair. A Physical Therapy progress note, dated 9/6/19, indicated the resident required maximum assistance for a sliding board transfer. A Physical Therapy Discharge Summary, dated 6/20/19 through 9/6/19, indicated the resident had received training in rolling, scooting and bridging to facilitate bed mobility. The resident was		Dependent residents (ADL score of 13 or above) were identified and care plans reviewed to determine ADL interventions are appropriate and in place. Any resident identified to have had a decline was re-assessed. **3) Measures put into place/ System changes:** Nursing and Therapy staff were in-serviced on the intent of regulation F676 and the provision of (ADL'S) activities of daily living. **4) How the corrective actions will be monitored:** MDS coordinator will review those residents triggering on the MDS for an ADL decline and bring information daily to scheduled morning meeting for discussion with IDT team to ensure appropriate services are received. The DON/ Designee will complete an audit daily x 5 days for 4 weeks, then three times a week for 4 weeks, then weekly for 4 weeks, and quarterly thereafter. The DON will report the results of audit at the QAPI Committee Monthly. The QAPI committee will determine when compliance is achieved or if ongoing monitoring is required. **5) Date of compliance:** 3-13-2020	

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	instructed on positioning maneuvers, proper body mechanics, safe transfer techniques and safety precautions to facilitate improved functional abilities. The resident's prognosis to maintain his current level of function was good with consistent staff follow through. To facilitate the resident's maintenance of his current level of performance and to prevent decline the instruction of the restorative nursing program had been completed with the interdisciplinary team. A care plan, dated 9/21/19, indicated the resident required a restorative nursing program related to his inability to transfer and bear weight for extensive time on his lower legs. The goals included active range of motion to assist the resident with range of motion to his ankles and the resident would be able to reposition himself in his bed with limited assistance. The interventions included, but were not limited to, allow the resident to perform the activity at his own pace, encourage participation to the fullest extent possible, the resident will roll from side to side in bed and use all extremities to scoot up in the bed. The care plan did not include transfers to the resident's wheelchair. A care plan, dated 7/1/19, indicated the resident had a self care deficit related to difficulty walking and weakness. The interventions included, but were not limited to, required one staff assistance to use the toilet, required one staff assistance to reposition and turn in bed and required physical assistance with transferring with the hoyer lift. The care plan had not been updated since 7/1/19 and did not include transfers to the wheelchair using a slide board as the resident had completed in physical therapy.			

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The resident's care plan did not include a preference for him to remain in bed.

A progress note, dated 12/27/19 at 7:39 p.m., indicated the resident had weakness to his ankles and feet which prevented the resident from being able to transfer safely by himself and would benefit from active range of motion to his lower extremities to return some independence. The resident would improve bed mobility.

During an interview, on 2/12/2020 at 10:34 a.m., the Therapy Manager indicated the resident had not been able to walk since admission due to his weak ankles and he was able to propel himself in his wheelchair. The resident indicated to the therapist he had past surgeries on his knee or his leg and had a compression fracture from an injury on his back. The resident kept his ankles and his legs rolled out and therapy had worked with him to keep his legs not rolled out. The resident preferred to be in bed and would be up in his wheelchair maybe once a week. The resident no longer received therapy services.

The resident's diagnoses did not include problems with his ankles, a history of compression fractures or a history of knee or leg fractures or surgeries.

During an interview, on 2/11/2020 at 3:18 p.m., the Executive Director (ED) indicated the resident did not want to get up in his wheelchair and he used to when he was first admitted. The staff had tried to assist the resident to use a walker when the resident was first admitted and he was not able to walk any distances. His legs had always been turned out and there was no diagnosis for the resident's leg problems.

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	The resident's record and staff interviews did not give a clear picture of the exact diagnoses, history of diagnoses, the reason the resident was in a wheelchair on admission, the medical necessity for the wheelchair and a clear plan to get the resident to return to his prior functioning of independently propelling his wheelchair or a medical reason the resident's prior functioning could not be obtained. A current policy, titled "Personal Bathing and Shower," revised on 4/25/18 and received from the Unit Manager on 2/12/2020 at 5:00 p.m., indicated, "...ADL's: Activities of Daily Living...activities that consist of ...include bathing, eating, grooming, dressing, transferring, and toileting...It is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident...Resident have the right to choose their schedules..." 3.1-38(a)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure non- pressure skin conditions were assessed for 1 of 4 residents reviewed for skin conditions (Resident 53).	F 0684	**F 684D Quality of Care** **The facility requests paper compliance for this citation.**	03/13/2020

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	Finding includes: During an observation, on 2/5/2020 at 11:36 a.m., Resident 53 had a growth on his right ring finger nail bed which stuck out and was approximately the size of a dime. During an observation, on 2/11/2020 at 9:38 a.m., the resident still had the growth sticking out of the fingernail on his right hand. During an observation, on 2/11/2020 at 1:14 p.m., the right hand ring finger growth remained and the resident had discolored areas on his left and right hand fingers which were dark red. The record for Resident 53 was reviewed on 2/7/2020 at 3:50 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, major depressive disorder and peripheral vascular disease. The physician orders did not include any type of treatment to the growth on the nail bed on the right ring finger. The weekly skin assessments did not include the growth on the resident's nail bed of the right ring finger. A care plan, revised on 8/30/18, indicated the resident had a risk for alteration in comfort related to frostbite areas to his fingers, depression and peripheral vascular disease. The care plan did not include the growth on the resident's nail bed.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident 53 skin assessment was completed and care plan updated. Resident 53 physician was contacted for any order updates. Family was contacted to review residents current plan of care.** **2) How the facility identified other residents: Director of Nursing/Designee/Wound Nurse completed a full wound audit to assure accuracy of skin documentation, current treatments in place, and care plan updated.** **3) Measures put into place/ System changes: In-service was conducted on**	

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	A physician's progress note, dated 6/7/18, indicated the resident had localized erythema and increased edema to the third finger on the right hand, the nail bed had necrotic tissue and the fingernail was absent. The plan included Keflex (an antibiotic) three times a day for 7 days. During an interview, on 2/12/2020 at 11:05 a.m., the Executive Director (ED) indicated the facility did not have a care plan for the abnormal tissue on the resident's fingernail, the resident had seen a physician who recommended a biopsy of the nail bed and there was no documentation to show the biopsy had been completed. The resident had a history of frostbite to his fingertips. A current policy, titled "Skin Care and Wound Management Overview," dated 7/1/16 and received from the Director of Nursing on 2/13/2020 at 7:45 p.m., indicated "...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds...The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition[s} contributing to it and description of impairment to determine appropriate treatment...Each resident is evaluated upon admission and weekly thereafter for changes in skin condition...Skin care and wound management program includes, but is not limited to...Daily monitoring of existing wounds...." 3.1-37(a) 3.1-37(b)		**Skin care and Wound Management to educate nurses on accurate completion of skin assessments. Nurses will complete weekly skin checks and wound assessments per policy** **4) How the corrective actions will be monitored: The Director of Nursing/Designee will audit 4 residents' skin checks and wound assessments weekly for 6 months to determine timely assessment, accuracy and care plan revision has occurred. Any identified issues will be corrected immediately Audit will be presented at QAPI monthly where trends and patterns will be reviewed and recommendations made to revise the plan of correction as indicated** . **5) Date of compliance: 3-13-2020**	
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			

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	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 ensure a physician's order for the use of hand splints to prevent the worsening of range of motion was completed for 1 of 10 residents reviewed for limited range of motion (Resident 31). Finding includes: The record for Resident 31 was reviewed on 02/10/20 at 10:56 a.m. Diagnoses included, but were not limited to, quadriplegia, epilepsy, contractures of right and left hands and spasmodic torticollis. During an observation, on 02/10/20 at 10:05 a.m., Resident 31 was in bed, awake, with the television on. Both of her hands were curled inward. No splint or hand rolls were in place. Soft splints for her hands were sitting on the chair next to her bed.	F 0688	F 688D Increase/Prevent Decrease in ROM/Mobility The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	03/13/2020

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	155222	A. BUILDING 00 B. WING	02/12/2020

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	During an interview, on 02/10/20 at 10:09 a.m., LPN 3 indicated the resident had soft splints, but she got irritated when they put them on her. LPN 3 wanted to show how the resident reacted to the splint placement so she left the room to get the occupational therapist (OT). During an observation, on 02/10/20 at 10:14 a.m., OT 4 came into Resident 31's room to apply the soft hand/wrist splints bilaterally. The resident did not display any facial grimacing while the splints were applied. The resident smiled afterwards. During an observation, on 02/12/20 at 01:48 p.m., Resident 31 was awake in bed. She was not wearing the soft hand/wrist splints. A physician's order, effective 10/21/19, indicated the resident was to wear both hand splints 4-8 hours a day per resident's tolerance based on facial expressions. Nursing was to monitor the resident for redness, splint comfort, edema, and notify therapy. An OT Discharge Summary, dated 10/23/19, indicated the recommendation was to ensure the resident maintained a current level of performance and to prevent decline. The development of and instruction in the following Registered Nurse Practitioners (RNPs) had been completed with the interdisciplinary team (IDT): Range of Motion (ROM)-Passive and splint or brace care. A care plan, dated 03/30/14, indicated the resident had an activity of daily living (ADL) self care deficit related to left and right hand contractures. The interventions included, but were not limited to, apply splints as ordered to both hands/wrists and to assist the resident with ADLs.		1) Immediate actions taken for those residents identified: Updated Physician order was obtain for splint application for resident 31 2) How the facility identified other residents: Audit was conducted of any active residents requiring splints to determine current orders were present. Any identified were immediately corrected. 3) Measures put into place/ System changes: Education provided to nursing staff regarding following physician orders and ensuring splints are in place as ordered. Angels will ensure splints are in place during their regular scheduled rounding. Identified issues will be reported to the Unit manager/Director of Nursing for correction 4) How the corrective actions will be monitored: Director of Nursing/Designee will conduct a splint audit 2 times weekly for 6 months to determine applications of splints as ordered. Identified issues will be addressed timely and result in re-education and or corrective actions. Results of splint audit will be taken to monthly QAPI for review. QA committee will identify trending or patterns and make recommendations to revise the	

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	The facility staff did not follow the physician's order for splint application or document why the order was not followed. A current facility policy, titled "Physician Orders," dated as revised on 12/1/18 and received from the Unit Manager on 02/12/20 at 8:50 a.m., indicated "...III. Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide the safe hand-off to the next nurse...ii. Update the MAR/TAR with changes or new orders...iii. Notify internal staff of changes/updates as appropriate...notify resident/resident representative of changes or new orders as appropriate...." 3.1-42(a)(2)		plan of correction as indicated. 5) Date of compliance: 3-13-2020	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to thoroughly investigate and provide a specific intervention after a witnessed fall for 1 of 5 residents reviewed for accidents (Resident 72). Finding includes: The record for Resident 72 was reviewed on	F 0689	F 689 Free Accidents Hazards/Supervision/Devices The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	03/13/2020

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	02/11/20 at 4:41 p.m. Diagnoses included, but were not limited to, cerebrovascular disease with hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side, end stage renal disease, spinal stenosis-cervical region, encephalopathy (the functioning of the brain affected by a viral infection or toxins in the blood), polyneuropathy (damage or disease affecting peripheral nerves causing weakness, numbness, or burning pain), convulsions and peripheral vascular disease. A progress note, dated 01/01/20 at 9:08 a.m., indicated the resident was witnessed sliding off of the side of the bed. There were no injuries noted or complaints of pain voiced. The Director of Nursing (DON), physician and family were notified. There were no adverse reactions noted. The resident would continue to be monitored. An Interdisciplinary team (IDT) note, dated 1/2/20 at 9:55 a.m., indicated the IDT discussed the resident's witnessed fall. The resident was barefoot. Nursing applied appropriate footwear after the resident had fallen out of bed. Staff were educated to ensure appropriate footwear was on while the resident was out of bed. The IDT did not identify the root cause of the fall and the reason the resident had tried to get out of bed on his own. A care plan, dated 8/13/14, indicated the resident was at risk for falls. Interventions included, but were not limited to, anticipate and meet the resident's needs, to administer medications as ordered-3/10/17, to place the call light within reach-8/13/14, to check for incontinency every 2 hours-11/14/18, to provide education to the		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #72 was assessed for fall risk and interventions reviewed. Care Plan was updated and staff educated on fall interventions 2) How the facility identified other residents: Fall audits were conducted for the past 60 days to determine thorough investigation had been conducted and care plans were reflective of interventions 3) Measures put into place/ System changes: Education conducted with nursing staff and IDT on thorough fall investigations and the provision of resident specific interventions to prevent accidents. 4) How the corrective actions will be monitored: The Director of Nursing/designee will conduct weekly fall audit on	

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	resident regarding the risks of ambulating on uneven planes by himself and to ask for assistance-11/30/17, to ask for assistance when ambulating in his wheelchair down the ramp-11/27/17, to ensure the resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair-3/10/17, to follow facility fall protocol-12/01/17 and to practice independence: education/reminders to ask for assistance with transfers-1/9/18. A care plan, dated 1/1/2020, indicated the resident had an actual fall with no injury. Interventions included, but were not limited to, determine and address the causative factors of the fall, monitor, document and report as needed for 72 hours to the physician for signs and symptoms of pain, bruising, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation and to obtain a pharmacy consult to evaluate medications. The intervention for the recent fall was not a new intervention and was not reflected as staff education for applying appropriate non-skid footwear while the resident was in bed. During an interview, on 02/12/2020 at 2:12 p.m., the DON indicated the intervention the IDT discussed was vague about the appropriate footwear and should have addressed the root cause of the witnessed fall. The Clinical Support verified the wording non-skid footwear would have made the intervention specific to the resident's root cause. No fall policy was provided, but the DON provided an Occurrence Incident Reporting policy. The DON and Clinical Support indicated they did not have a fall policy, but only an occurrence incident reporting policy.		those residents identified to have had a fall. Falls\accidents will be reviewed with IDT during scheduled stand up meetings for appropriate intervention, thorough investigation, root cause analysis, and care plan revision. Any area of concern will be addressed immediately. Audits submitted weekly to regional clinical support for review. Results of audits will be reviewed at monthly QAPI meeting. The committee will review patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 3-13-2020	

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	3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to re-weigh a resident after a weight change of 5 pounds or more and to complete weekly weights as ordered for 3 of 5 residents reviewed for nutrition (Resident 17, 7 and 27). Findings include: 1. The record for Resident 17 was reviewed on 02/07/20 at 1:59 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the right dominant side, vascular dementia with behavioral	F 0692	F 692 D Nutrition Hydration Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	03/13/2020

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	disturbance, aphasia following other cerebrovascular disease and cognitive communication deficit. A review of the resident's weights indicated the following weights: a. On 11/18/19, the resident weighed 193 pounds (lbs.). b. On 12/16/19, the resident weighed 194.2 lbs. c. On 1/1/20, the resident weighed 186.4 lbs., which was a 7.8 pound (lb.) or 4.02% weight loss. d. On 1/30/20, the resident weighed 175.6 lbs., which was a 10.8 lb. or 5.79% weight loss. During an interview, on 2/11/20 at 2:52 p.m., the Director of Nursing (DON) indicated the residents were usually re-weighed if there was a 5-pound or more variance from the previous weight. The resident was not re-weighed to verify his weight after the 7.8 lb. weight loss on 1/1/20 or after the 10.8 lb. weight loss on 1/30/20.2. The record for Resident 7 was reviewed on 2/7/2020 at 4:08 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anorexia, anemia, major depressive disorder and dementia without behavioral disturbance and dysphagia (difficulty swallowing). A physician's order, dated 1/30/2020, indicated the resident was to receive a regular diet, regular texture and thin consistency. A physician's order, dated 6/28/19, indicated to give ensure three times a day between meals for wound healing. The resident had the following weights: a. On 1/20/2020, the resident's weight was 98.7 pounds. b. On 1/29/2020, the resident's weight was 110.6		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 7, 17 and 27 were assessed, re-weighed, care plans reviewed and updated, and residents' family and physician were notified. 2) How the facility identified other residents: Active residents' records were reviewed for current significant changes with updates made to physician and families. RD reassessed residents who have had recent significant changes progress notes were completed, and recommendations made as appropriate. 3) Measures put into place/ System changes: Licensed nursing staff were educated on obtaining accurate weights and re-weights. The Registered Dietitian will meet with the DNS/Unit Manager weekly for scheduled SNAR meeting. Registered Dietician will provide the Director of Nursing nutritional recommendations prior to exiting the facility with specific attention	

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	pounds which was a 12.06% weight increase. c. On 2/10/2020 the resident's weight was 117 pounds which was an additional 5.7% weight increase. During an interview, on 2/12/2020 at 5:11 p.m., the DON indicated the re-weights were not completed after the significant weight gains and there was no documentation the physician was notified of the significant weight gains. 3. The record for Resident 27 was reviewed on 2/7/2020 at 4:39 p.m. The diagnoses included, but were not limited to, anoxic brain damage, protein calorie malnutrition, gastrostomy status, vitamin D deficiency and degenerative disease of the nervous system. A care plan, not dated, indicated the resident had inadequate/suboptimal oral food and beverage intake related to a lack of desire for oral intake and a tube feeding as his primary source of nutrition and hydration to maintain an appropriate weight. The interventions included, but were not limited to, administer water and fluids by the gastrostomy tube and to monitor and evaluate weights. A Nutritional Review Assessment, dated 12/10/19, indicated the Registered Dietician (RD) recommended weekly weights to better monitor the nutritional status with the resident's tube feedings and his limited by mouth intake. The resident did not have a weekly weight documented on 12/24/19 or 1/14/2020. During an interview, on 2/12/2020 at 5:16 p.m., the DON indicated the RD wrote the recommendation of the weekly weights on the electronic assessment form and did not provide a separate		made to significant changes. Identification of significant weight changes will be reported timely to the physician, and family. Care plans will be updated as needed. 4) How the corrective actions will be monitored: The responsible party for this plan of correction is the Director of Nursing/Unit Manager/designee. Weights will be reviewed daily during scheduled stand up meeting and weekly during Skin and Nutrition at Risk meeting. Weight audits completed 2 times weekly to determine weekly weights and re-weights are completed and accurately documented, and physician and family notifications occurred. The results of these audits will be reviewed in QAPI monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 3-13-2020	

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	recommendation so the weekly weights were not completed for the resident. A current policy, titled "Resident Weight," revised on 5/19/16 and received from the Unit Manager on 2/12/19 at 10:10 a.m., indicated, "...Accurate weight...obtain weight in the morning before meals and post voiding for the most accurate body weight...Weekly weights...Recommend that residents with tube feedings be weighed weekly...Reweight Parameters...A plus/minus of 5 pounds of weight in one week will result in...Reweight within 24 hours...Validation with nurse for accurate weight...Notify IDT[interdisciplinary team]/doctor/family...." 3.1-46(a)(1)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to arrange for a psychiatric consult for 1 of 4 residents reviewed for behavioral and emotional services (Resident 14). Finding includes:	F 0740	F740 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of	03/13/2020

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	The record for Resident 14 was reviewed on 02/6/20 at 2:16 p.m. Diagnoses included, but were not limited to, cardiomyopathy, alcohol abuse with unspecified alcohol-induced disorder, alcohol cirrhosis of liver without ascites, metabolic encephalopathy, mild cognitive impairment, left hand contracture and right hand contracture. A care plan, initiated on 11/14/19, indicated the resident was depressed and the facility would arrange for a psychiatric consult. During an interview, on 2/12/20 at 4:36 p.m., the Executive Director (ED) indicated a care plan for a psychiatric consult was initiated on 11/14/19. The facility did not make a referral for psychiatric services. During an interview, on 2/12/19 at 5:02 p.m., the Director of Nursing (DON) indicated the psychiatric referrals were the responsibility of social services. A current policy, titled "Behavior Management General," revised 4/8/16 and received from the ED on 2/11/2020 at 10:30 a.m., indicated "...It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses...Residents will be provided with a resident centered behavior management plan to safely manage the resident and others...." 3.1-43(a)(1)		compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Psychiatric Consultation was arranged for Resident 14. Resident was assessed and plan of care reviewed. 2)How the facility identified other resident: An audit was completed for those residents that triggered greater that a 10 on the PHQ-9. Any resident identified was reviewed for psychiatric consultation, Assessments and revisions of plan of care completed. Residents will be identified upon admission, quarterly, with significant change and annual assessments. 3)Measures put into place/ System changes: Social Services was educated on the components for F 740 and the provision of necessary behavioral health care.	

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			4)How the corrective actions will be monitor The Director of Nursing /Designee and Social Services will review 3 residents weekly to ensure the provision of behavioral and emotional services and psychiatric consultation has been arranged as needed. Any issues will be addressed immediately. Results of audits will be taken to QAPI for 6 months. The Committee will review for trends and patterns and make recommendations to the plan of correction. 5) Date of compliance: 3-13-2020	
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on interview and record review, the facility failed to obtain an accurate history to provide	F 0742	F742	03/13/2020

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	mental health services for 1 of 4 residents reviewed for behavior and mood (Resident 52). Finding includes: The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, morbid obesity and major depressive disorder. During an interview, on 2/5/2020 at 1:45 p.m., the resident was very irritable and indicated he was getting kicked out of the facility. He used to get up in the wheelchair all the time and was no longer able to get into the wheelchair and spent most of his time in bed. He ate meals in his room and watched television in his room. An admission progress note, indicated the resident had been seen previously by [name of provider] behavioral health services. During an interview, on 2/7/2020 at 3:00 p.m., the Executive Director (ED) indicated the facility had not obtained the records from the previous behavioral health services provider and did not know if the resident had any past mental health diagnoses. The records from the previous behavioral health services provider, indicated on 6/11/19, the resident's primary diagnosis was a dependent personality disorder (characterized by an inability to make decisions even everyday decisions like what to wear which could cause anxiety. Treatment for this disorder often included behavioral health therapy and medication for anxiety or depression). The provider was working on getting the resident housing instead of the resident sleeping on the streets and had		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Psychiatric Consultation was arranged for Resident 52. Care Plan was updated to reflect Dependent Personality Disorder. 2) How the facility identified other resident: Residents will be identified through the admission process, quarterly and significant change assessments and annual review. 3) Measures put into place/ System changes: Social Services was educated on the components for F 742 and the provision of mental health services.	

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	155222	A. BUILDING 00 B. WING	02/12/2020

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	submitted paperwork for a possible nursing home placement. The facility care plans for Resident 52 did not include the dependent personality disorder. During an interview, on 2/7/2020 at 4:10 p.m., the ED indicated the facility was not aware the resident was diagnosed with a dependent personality disorder. She indicated the addition of this diagnoses may assist the resident to get Medicaid or Medicare coverage for his stay at the facility. A current policy, titled "Behavior Management General," dated as revised 4/8/16 and received from the ED on 2/11/2020 at 10:30 a.m., indicated "...It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses...Residents will be provided with a resident centered behavior management plan to safely manage the resident and others...." During an interview, on 2/11/2020 at 10:30 a.m., the ED indicated there was no policy for mental health services. 3.1-43(a)(1)		4) How the corrective actions will be monitor The Director of Nursing /Designee and Social Services will review 3 residents weekly to ensure the provision of behavioral and mental health services and psychiatric consultation has provided. Any issues will be addressed immediately. Results of audits will be taken to QAPI for 6 months. The Committee will review for trends and patterns and make recommendations to the plan of correction. 5) Date of compliance: 3-13-2020	
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.			

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	§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 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 over-the-counter (OTC) medications were labeled and medications were given when dispensed for 2 of 3 medication carts reviewed and failed to ensure medications were discarded when a resident discharged and expired supplies were removed from the medication rooms for 2 of 2 medication rooms reviewed (Central Hall, North Hall, South Hall and West Hall). Findings include: 1. During a medication storage review, on 02/11/2020 at 2:27 p.m., with LPN 3 in attendance, the back medication cart for the Central Hall was observed to have a (name of store) grocery bag which contained the following OTC medications without a label: a. One unopened bottle of (name of brand) Allergy Relief medication.	F 0761	F 761 E Label/Store Drugs and Biologicals The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	03/13/2020

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	b. One unopened bottle of Saline Nasal Spray. c. Two unopened bottles of smooth dissolving antacid. d. One unopened box of (name of brand) pain relief cream. e. Two unopened bottles of Acetaminophen 500 mg (milligram) pain reliever. f. Two bottles of Blood Glucose strips. g. Two unopened bottles of Aspirin. h. One unopened bottle of Ibuprofen. i. One box of (name of brand) pain relieving patches. During an interview, on 02/11/2020 at 2:29 p.m., LPN 3 indicated she did not know who the medications belonged to since the medications were not labeled as they should have been. During an interview, on 02/11/2020 at 2:33 p.m., the Unit Manager indicated the medications should not be in the medication cart without being properly labeled. At this time, she removed the bag of medications from the cart. 2. During a medication storage review, on 02/11/2020 at 2:35 p.m., with RN 10 in attendance, the North Hall medication cart was observed to have a clear plastic medication cup, in the top drawer, which contained two (1 round and 1 oblong) pills. A resident's name was not on the medication cup. During an interview, on 02/11/2020 at 2:36 p.m., RN 10 indicated she worked the day shift, did not notice the medication cup with the pills, did not know who placed the medication cup in the top drawer or who the medications were dispensed for. 3. During a medication storage review, on		1) Immediate actions taken for those residents identified: No resident was identified to have been affected Medications identified with no label were removed for medication carts and medication rooms. Supplies identified to all medication rooms to be expired were removed and discarded. Medications identified in med cup in North med were destroyed. 2) How the facility identified other residents: Medication storage audit was conducted. Any resident had the potential to be affected however none were identified. 3) Measures put into place/ System changes: In-servicing conducted with licensed nurses and qualified medications aides on the Storage of Medications, which included OTC medications, labeling, expired supplies and expired medications. Nurses will store medications per policy. Pharmacy contacted and audit conducted on medication storage. 4) How the corrective actions will be monitored: Director of Nursing/Designee will conduct a medication/supply audit 2 times weekly which will include medication carts and medication	

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	02/11/2020 at 3:14 p.m., with LPN 11 in attendance, the South Hall medication room was observed to have the following: a. One box of Acetaminophen 650 mg suppositories for Resident 127, dated as opened 02/01/2020. Resident 127 discharged from the facility on 11/24/2019. b. Five "Vacutainer Safety-Lok Blood Collection" sets which were dated as expired 04/2018. c. Two "Vacutainer" needles (needles used for collecting blood) which were dated as expired 11/2018. d. One "Insyte Auto Guard," 22 gauge, (used for collecting blood) which expired on 11/30/19. e. One "Insyte Auto Guard," 20 gauge, which expired 04/2017. f. One "Insyte Auto Guard," 24 gauge, which expired on 12/31/19. g. One "Universal Viral Transport" (used to collect viral samples) which expired 05/2019. h. Two emergency drug boxes (E-Kits), which contained medications, with an expiration date of 10/2019. During an interview, on 02/11/2020 at 3:20 p.m., LPN 11 indicated the expired supplies should have been removed from the medication room and the medication for Resident 127 should have been removed or disposed of when the resident discharged from the facility. 4. During a medication storage review, on 02/11/2020 at 3:39 p.m., with LPN 12 in attendance, the West Hall medication room was observed to have one box of skin prep protective wipes (a liquid film-forming wipe which forms a protective film on the skin) which expired on 05/2015. During an interview, on 02/11/2020 at 3:40 p.m., LPN 12 indicated the skin prep wipes were expired		rooms. Identified issues will be immediately addressed with corrective action and re-education. Audits will be taken to QAPI for 6 months. QA committee will review trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 3-13-2020	

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	and should have been discarded. A current facility policy, titled "Storage of Medications," not dated and received from the Unit Manager on 02/11/2020 at 3:27 p.m., indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...Medication storage conditions are monitored on a regular basis by the consultant pharmacist and corrective action taken if problems are identified...." 3.1-25(j) 3.1-25(p)			
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures			

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	determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. Based on interview and record review, the facility failed to arrange for a dental consultation for 2 of 9 residents reviewed for dental services (Residents 14 and 52). Findings include: 1. The record for Resident 14 was reviewed on 02/6/20 at 2:16 p.m. Diagnoses included, but were not limited to, cardiomyopathy, alcohol abuse with unspecified alcohol-induced disorder, alcohol cirrhosis of liver without ascites, metabolic encephalopathy, mild cognitive impairment, left hand contracture and right hand contracture. A "Dental Referral" admission assessment, completed on 11/4/19, indicated the resident needed a dental referral. During an interview, on 2/12/20 at 4:36 p.m., the Executive Director (ED) indicated the "Dental	F 0790	F 790 Routine Emergency Dental Services in SNF The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	03/13/2020

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	Referral" assessment, dated 11/4/19, confirmed the need for a dental referral. The facility did not make a referral for dental services. During an interview, on 2/12/20 at 5:02 p.m., the Director of Nursing (DON) indicated dental referrals were the responsibility of the social service department. 2. The record for Resident 52 was reviewed on 2/7/2020 at 2:05 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, morbid obesity and major depressive disorder. A care plan, dated 12/31/19 , indicated the resident was at risk for chronic pain related to carious (decayed) teeth. The interventions included, but were not limited to, administer analgesia as ordered, anticipate the need for pain relief and respond immediately to any complaints of pain and monitor for signs and symptoms of nonverbal pain. A care plan, dated 12/31/19, indicated the resident had oral/dental health problems related poor oral hygiene. The interventions included, but were not limited to, coordinate the arrangements for dental care and transportation as needed. A progress note, dated 12/20/19 at 3:21 p.m. indicated the resident returned from [name of dental office] without being treated since the office could not accommodate the resident on a stretcher. The resident was referred for a full mouth tooth extraction and had requested IV (intravenous) sedation which the office did not do. The facility would have to find another dental provider. The resident's record did not include the contact or scheduling of another provider to meet the		1) Immediate actions taken for those residents identified: Resident 14 dental referral was made and appointment scheduled. Resident 52 had referral sent to IU school of Dentistry r/t requirements of sedation needed for dental procedure. IU accepted referral of Resident 52 but will contact facility for scheduled of appointment. Weekly follow calls to IU School of Dentistry until appointment validation per Social Services and documented in clinical record. 2) How the facility identified other residents: Audit was conducted those residents that currently have dental concerns Facility audit conducted of new admissions to determine need of dental referrals. Areas identified resulted in dental referrals. Residents will be identified through the admission process, quarterly, significant change, and annual assessments 3) Measures put into place/ System changes: Facility staff were educated to notify social services immediately should dental issues be identified. Education provided regarding the components of F790 for obtaining routine and emergency care 4) How the corrective actions will	

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	resident's dental needs. During an interview, on 2/11/202 at 1:29 p.m., the Social Services Director (SSD) indicated the resident wanted IV sedation to have his teeth pulled and she was trying to locate an oral surgeon. She had not documented this information in the electronic record and had not updated the resident's care plan. A current policy, titled " Dental Services," dated as revised on 4/25/18 and received from the Executive Director on 2/12/2020 at 10:10 a.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident...Dental and Oral health can impact the physical as well as the mental/emotional and psychological health of a resident. Poor dentition/or poor oral health may impact nutrition...The facility will assist the resident in...Obtaining routine Dental Services...Obtaining services to the resident to meet the needs of each resident...Making appointments...If any resident is unable to pay for dental services, the facility should attempt to find alternative funding sources or delivery systems so that the resident may receive the services needed to meet their dental needs...This can include finding other providers of dental services...Care plan...Provide care planning specific to the resident for dental and oral health concerns...Document appointments and concerns in the EHR [electronic health record]...." 3.1.-24(a)(1) 3.1-24(b)		be monitored: The responsible party for this plan of correction is the Director of Nursing/Designee Audits will be conducted on 3 residents weekly to include new admissions for 6 months to ensure identified dental concerns were addressed and referrals made as required. Results will be taken to QAPI monthly. The committee will review and make recommendations to revise the plan of correction as indicated 5) Date of compliance: 3-13-2020	
F 0842 SS=D	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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Bldg. 00	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in			

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	compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to maintain accurate Medication Administration Records (MARs) for 1 of 1 resident reviewed for accuracy of records (Resident 7). Finding includes: The record for Resident 7 was reviewed on 2/7/2020 at 4:08 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension and dementia.	F 0842	F842 D Resident Records-Identifiable Information The facility respectively requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or	03/13/2020

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	A physician's order indicated to give Basaglar Kwikpen (an insulin) 20 units at bedtime for diabetes. The MAR, dated 11/1/19 through 11/30/19, was not signed on 11/2/19 to indicate the Basaglar was administered. The MAR, dated 12/1/19 through 12/31/19, was not signed on 12/1/19, 12/14/19 and 12/30/19 to indicate the Basaglar was administered. The MAR, dated 1/1/2020 through 1/31/2020, was not signed on 1/13/2020 to indicate the Basaglar was administered. The MAR, dated 2/1/2010 through 2/11/2020 , was not signed on 2/5/2020 and 2/10/2020 to indicated the Basaglar was administered. During an interview, on 2/12/2020 at 5:11 p.m., the Director of Nursing (DON) indicated she did not find any documentation to include if the Basaglar insulin was administered or not on the days the MAR was not signed. A current policy, titled " Clinical Documentation Standards," dated as reviewed on 5/29/19 and received from the Unit Manager on 2/13/2020 at 7:45 p.m., indicated "...Maintaining the integrity, quality, and safety of medical records can help to provide an effective communication between practitioners that may serve to enhance resident outcomes...A complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual resident is known...Basic Nursing Standards of Documentation...Clinical evidence of		agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: Resident 7 was assessed, medications and care plans reviewed and physician notified of undocumented areas to medication administration record. No adverse reactions noted. 2) How the facility identified other residents: A medication administration audit was completed over the last 30 days to determine medications were administered and documented correctly. Any issue identified were addressed timely and resulted in 1-1 re-education/corrective actions of identified nursing staff. 3) Measures put into place/ Systemic changes: Nursing staff was in-serviced on Clinical Documentation Standards. 4) How the corrective actions will be monitored: Director of Nursing/designee will complete a medication administration audit 5 times	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care and treatment records as evidence of care...The nurse is expected to...Document accurately and truthfully...Document entries during the work shift and complete all entries before leaving the facility for that tour/shift...." 3.1-50(a)(1) 3.1-50(a)(2)		weekly for 4 weeks then 3 times weekly for 4 weeks, then weekly thereafter for 6 months Concerns identified will be addressed and corrected. The DON will report the results of these audits will be reviewed in Quality Assurance Meeting Monthly. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) D.O.C 3-13-20	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to provide a stop date and a clinical rationale for the use of an antibiotic for 1 of 1 resident reviewed for antibiotic use (Resident 36). Finding includes: The record for Resident 36 was reviewed on 2/12/20 at 9:43 a.m. Diagnoses included, but were not limited to, unspecified retention of urine, bipolar type schizoaffective disorder, unspecified dementia without behavioral disturbance, chronic	F 0881	F 881D Infection Preventionist The facility respectfully requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement	03/13/2020

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	155222	A. BUILDING 00 B. WING	02/12/2020

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	respiratory failure with hypoxia, weakness and difficulty walking. A physician's order, dated 11/11/19, indicated Macrobid Capsule (an antibiotic medication) 100 milligram (mg) by mouth two times a day for prophylactic (prevention). The physician's order did not indicate what type of infection was being prevented by the medication. The "Long Term Care Pharmacist Recommendation," dated 12/12/19, requested a potential stop date for the Macrobid. The physician response to the pharmacist's recommendation indicated the patient was consulting with urology and the Macrobid should continue prophylactically without a stop date. The physician's response did not include a clinical rationale for the prophylactic use of the antibiotic. During an interview, on 2/12/2020 at 4:06 p.m., the Director of Nursing (DON) indicated Resident 26 had not consulted with urology. The facility should have had a rationale for the prophylactic use of the Macrobid. The facility did not have a stop date or a rationale for the Macrobid. A current facility policy, titled "Antibiotic Stewardship Plan," dated as effective 05/01/2017 and provided upon entrance, indicated "...The Medical Director will have access to and review antibiotic use data and ensure best practices are being followed...Develop relationship with infectious disease consultants to work to reduce antibiotic use and experience lower rates of infection including but not limited to...Infectious Disease (ID) Physicians...The Antibiotic		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Physician was contacted and medication was discontinued for Resident 36 2) How the facility identified other residents: Audit was conducted to identify residents that are currently on antibiotics to determine they meet criteria for use. If antibiotic does not meet criteria the physician was contacted to provide sound reasoning for their decision and conversation was documented in the clinical record. 3) Measures put into place/ System changes: Nursing staff were in serviced on infection prevention and infection surveillance criteria. Infections will be documented on the infection monitoring form and reviewed during monthly infection control meeting. The Pharmacy will provide a list of all antibiotics ordered for the month. 4) How the corrective actions will	

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	Stewardship engages facility leadership, subject matter experts, front-line staff, residents, families and community to partner to reduce the use of unnecessary antibiotic use...." 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)		be monitored: The Director of Nursing /Infection Preventionist will review weekly those residents identified to have ordered antibiotics to determine criteria has been met by utilizing the resident monitoring tool. The infection control Committee will meet at least monthly to review those residents that were prescribed antibiotics to determine infection criteria has been met. Results of above reviews will be reported to QAPI monthly. The Committee will review for trending or patterns and make recommendations as required to the plan of correction. 5) Date of compliance: 3-13-2020	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a clean and sanitary environment in the main dining area and all three resident units and to maintain water temperatures of at least 100 degrees for 1 of 3 shower rooms. This deficient practice had the potential to effect 78 of 78 residents who resided in the facility. Findings include:	F 0921	F 921 F Environmental Conditions The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	03/13/2020

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	1. During the initial tour of the facility, on 02/05/2020 at 12:57 p.m., the following were observed: a. There was missing paint on the walls close to the baseboards and between the windows in the television room next to the dining area. b. The tiles on the floor between the dining room and television room had cracks and part of the tiles were missing. c. The door closest to the kitchen had gouges and missing paint closest to the kitchen area. d. The wall next to the fireplace had scrapes and missing paint. e. There was a gouged area on the wall, in the middle of the dining area, closest to the kitchen and next to the baseboard trim. f. The wall next to the clock had gouges and missing paint with part of the chair rail missing next to the fichus tree. g. The doorway to the dining area had gouges and missing paint. h. The doorway next to the exit, with the nutrition supervisor across the hall, had gouged areas and missing paint. i. The floor next to the beverage dispenser, closest to the kitchen, had dirty cabinets and there were partially missing floor tiles with unattached baseboard trim. j. There was trash on the floor next to the missing floor tiles. k. The wall behind the sink was dirty. l. The paint was peeling in the corner. During an observation, on 02/05/20 at 1:09 p.m., the door to the nutrition services was very dirty with black marks all over it on the hallway side and the door to the dietary office had black marks all over the bottom of the door closest to the floor. During an observation, on 02/10/2020 at 2:31 p.m.,		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No resident was identified to have been affected by identified needed painting and floor repairs. Mixing valve was adjusted Resident 68 denied missing any shower related to water temperatures. A) Television room-painting completed. B) Television room tiles missing and cracks- Installation of new flooring quote obtained 2-18-2020 C) Door repaired of gouges and painted D) Wall next to fireplace repaired of scrapes and painted E) Gouged wall in dining area repaired F) Wall next to clock with gouges and missing paint repaired; chair rail repaired G) Doorway to dining area with gouges repaired and painted H) Doorway/Exit across for nutrition supervision gouged areas were repaired and painted I) Floor beside beverage dispenser with missing tiles-new flooring quote received 2-18-2020; Dirty	

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	there were cracked floor tiles and an uneven surface in the hallway outside of the Social Services office. During an interview, on 02/05/2020 at 1:06 p.m., the Dining District Manager indicated maintenance had looked at the missing tiles and was aware of the need for repair or replacement. During an interview, on 02/12/20 at 10:10 a.m., the maintenance technician indicated the painting touch up or drywall mud and sand was on the preventative maintenance plan which he had not gotten to yet. The facility had a budget plan in place to have the floor replaced. He did not have a preventative floor plan in place. He indicated a floor technician should report any broken floor tiles to the Maintenance Director. 2. During an interview, on 02/06/2020 at 3:37 p.m., Resident 68 indicated during the middle of a shower, the water would get either really cold or too hot and it was difficult to regulate the water temperature. During an interview, on 2/11/20 at 8:39 am, CNA 2 indicated when she had taken residents to the shower, she has had to readjust the water temperature because of the temperature fluctuations. Several residents did not think the water temperature was hot enough. During an observation, on 2/12/2020 at 9:54 a.m., the south unit's shower water was left running and the temperature was 97 degrees Fahrenheit after 5 minutes and after 10 minutes the water temperature was 92 degrees Fahrenheit. The maintenance technician indicated the water temperature was below 100 degrees and therefore was not suitable. He read the mixing valve which		cabinets were cleaned and baseboard trim attached J) Trash was removed from the floor K) Wall was cleaned behind the sink L) Identified peeling pain in the corner was repaired The door to nutritional services and dietary office was cleaned/repaired/painted. Preventative floor plan was developed. 2)How the facility identified other resident: Any resident that was provided a shower on 2/12/2020 in South unit shower room had the potential to be affected, however none were identified. Per interview no resident residing on South voiced complaints of water temperature. No resident was identified to have been affected related to identify needed facility painting, and floor repairs. 3) Measures put into place/ System changes: Identified facility repairs (painting, cleaning, floors) will be placed on a Preventative Maintenance Plan. Monitoring of water temps conducted 3 times weekly. Identified Issues will be immediately addressed In-servicing will be completed with staff on reporting maintenance concerns (ie water Temps) through	

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	registered 93 degrees before he adjusted it. The ED provided a copy of the water temperature checks log on 2/12/2020 at 2:45 p.m. The document, titled "Inspect air and water temperatures," indicated "...1. Hot water temperatures meets regulatory requirements...3. IN- 100-120 degrees Fahrenheit...." 3.1-19(f)(5) 3.1-19(r)(1)		TELS system.Educated staff to notify their supervisor should any resident voice concerns regarding water temps 4) How the corrective actions will be monitored: Responsible party for this plan of correction is the joint effort of the Administrator/Maintenance Director who will round 2 times weekly. Identified areas are placed on a PM log for follow up. Audits will be conducted 3 times weekly of water temps to determine temperatures meet regulatory requirements. Identified areas will be immediately addressed. Any issues with water temperatures will be reviewed during daily stand up meetings. The results of these audits will be reviewed in QAPI monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 3-13-2020	