STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	09/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 12, 13, 14, 15, 18, 2017. Facility number: 011032 Provider number: 155683 AIM number: 200262860 Census bed type: SNF/NF: 1 NF: 22 Total: 23 Census payor type: Medicaid: 23 Total: 23 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 25, 2017	F 0000	Please accept this as our credible allegation of compliance.	
F 0226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT,			

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

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Bldg. 00	ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on interview and record review, the facility failed to implement its' abuse policy by not obtaining a criminal background check prior to employment for 1 of 1 new employee files reviewed (CNA #1). Findings include:	F 0226	The Administrator revised the employee hiring policy and staffed it with the Business Office Manager. He reiterated the fact that no employee was to begin work without a police report. All residents had the potential to be affected by this deficient practice. All other employee records were	10/18/2017

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	The employee file for CNA #1 was provided by the Business Office Manager (BOM) on 9/14/17 at 2:15 p.m. The employee records form indicated CNA #1 started employment on 7/19/17. The file contained a criminal background check dated 8/2/17. During an interview with the BOM, on 9/14/17 at 2:25 p.m., she indicated CNA #1 started employment on 7/19/17 and the background check was obtained on 8/2/17 because she was unsure on how to obtain the report. A policy titled Abuse Prevention, no date, was provided by the Administrator on 9/14/17 at 2:58 p.m. The policy indicated "...Preventing abuse...Effective employee hiring and screening processes to screen about potential abusers...." On 9/14/17 at 3:14 p.m., the Administrator indicated one component of an effective hiring and screening process, as mentioned in the policy, was to obtain a criminal background check prior to employment and a background check should've been obtained prior to CNA #1's employment. A document provided by the Administrator on 9/15/17 at 1:41 p.m.,		checked. They all had police reports in the employee files. All new employees will be staffed with the Administrator by the Business Office Manager. He will check to ensure that all background checks are completed before any potential employment will begin. This will be monitored by the Administrator monthly for 6 months and then every 3 months by the QA Committee.	

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	indicated CNA #1 worked 6 days in the facility prior to when the criminal background check was obtained. 3.1-28(a)			
F 0250 SS=D Bldg. 00	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility failed to notify a State Agency that a Resident was no longer receiving mental health services from a specific provider for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (Resident 15). The facility also failed to ensure follow up with mental health services after a resident's inpatient psychiatric hospitalization for 1 of 5 residents reviewed for unnecessary medications. (Resident 21) Findings include: 1. The clinical record for Resident 15 was reviewed on 9/13/17 at 10:45 a.m.	F 0250	Residents numbered 15 & 21 were seen by Great Lakes Institute for neuro-psychology and behavioral health conditions on September 15, 2017. All recommendations from them were followed. All residents had the potential to be affected by this deficient practice. All other records were audited and all that have mental health conditions have been seen by the mental health provider. There will be a mental health book put in place for all residents with mental health conditions. This book will contain the dates that all residents will be seen and all recommendations will be kept in this	10/18/2017

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	The diagnoses for Resident 15 included, but were not limited to, schizophrenia, anxiety, insomnia, and dementia with behaviors. A Preadmission Screening Determination, dated 7/12/15, indicated, "...continue current MH [mental health] services...Other-Specify-No further YRR [Yearly Resident Review] required as long as resident remains [name of specific mental health/psychiatry services provider] client...." The last [name of specific mental health/psychiatry services provider] notes indicated Resident 15 was last seen on 4/13/17 with "...Instructions...Return in about 3 months (around 7/13/17) for next scheduled follow up...." During an interview with the Social Services Director (SSD), on 9/14/17 at 11:19 a.m., the SSD indicated [name of specific mental health/psychiatry services provider] had not been in the building for awhile, but she will look to see if there were any other mental health visits after 4/13/17. At 11:42 a.m., on 9/14/17, the SSD indicated there was no other mental health/psychiatry visits since 4/13/17 and [name of specific mental		book. This will be a standalone book that will be kept at the nurse's station. An extra copy of this book will be kept by the Social Services Director for inter-departmental communications between Social Services and Nursing. This will be monitored monthly by the Director of Nursing and Social Services Director for 6 months and then quarterly by the QA Committee going forward.	

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	health/psychiatry services provider]'s contract was canceled by the facility. She doesn't remember exactly when the contract was terminated but it's been awhile. A different mental health provider was in contract with the facility now. On 9/14/17 at 11:53 a.m., the Director of Nursing indicated the "new" mental health provider's contract started 7/1/17 but she was unsure of the exact date when [name of specific mental health/psychiatry services provider] services ended. During an interview with the SSD, on 9/14/17 at 2:58 p.m., the SSD acknowledged the Preadmission Screening Determination, dated 7/12/15, indicated, "...No further YRR [Yearly Resident Review] required as long as resident remains [name of specific mental health/psychiatry services provider] client...." but she did not contact the State Agency that Resident 15 was no longer seeing [name of specific mental health/psychiatry services provider] because the facility obtained another mental health provider. Resident 15 had not been seen by the "new" mental health provider yet or any other mental health provider since the above mental health visit in April.2. The clinical record for			

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	Resident 21 was reviewed on 9/13/17 at 9:52 a.m. The diagnoses for Resident 21 included, but were not limited to: bipolar disorder, fibromyalgia, anxiety, and depression. She was admitted to the facility on 1/18/17. The 4/3/17 social services note indicated Resident 21 was sent to the hospital for psychiatric evaluation. The 4/13/17 social services note indicated Resident 21 returned to the facility on 4/7/17 from (name of hospital) psychiatric unit. The 4/7/17 (Name of Hospital) Discharge Summary Note read, "Admission Condition: Serious...presented with reports of mood disturbance and anxiety...Patient was admitted to psychiatric unit on a voluntarily (sic) basis....Patient attended unit groups and developed coping skills and greater insight into symptoms of illness and treatment....With inpatient treatment patient's condition improved....At discharge patient was future oriented and free of any suicidal or homicidal thoughts....Unit social worker/Case Manager coordinated discharge plans...Patient Instructions: Reviewed discharge medications with patient. Reviewed discharge diagnosis with			

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	patient. Reenforced (sic) importance of follow up care....Follow up with (name of facility). Why: Will be returning to (name of facility) and they have informed that they will schedule f/u (follow up) with (name of mental health center)." There was no information in the clinical record to indicate follow up with mental health services after Resident 21 returned to the facility on 4/7/17. An interview was conducted with the SSD (Social Services Director) on 9/14/17 at 11:41 a.m. She indicated Resident 21 had not received any mental health services since her 4/7/17 return to the facility. An interview was conducted with the SSD on 9/15/17 at 2:30 p.m. She indicated she usually received paperwork after an inpatient psychiatric hospitalization or the paperwork was given to her. She stated, "I like to know, so I know if there's anything I need to do or follow up on." She reviewed the 4/7/17 hospital discharge paperwork and stated, "This is my first time seeing this. I haven't read this until now." An interview was conducted with Resident 21 on 9/15/17 at 2:51 p.m. She indicated she was willing to be seen by a			

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	mental health provider. 3.1-34(a)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.			

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	(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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			

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	their resident representative is determined not practicable for the development of the resident's care 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 revise dental and vision care plans for 1 of 2 residents reviewed for dental and 1 of 3 residents reviewed for vision (Resident 5). Findings include: 1a. The clinical record for Resident 5 was reviewed on 09/14/17 at 11:45 a.m. The diagnoses for Resident 5 included, but were not limited to, depression, dementia with psychosis and behaviors with aggression. During an observation, on 9/13/17 at 9:45 a.m., Resident 5 was observed with several missing and discolored teeth. During an interview with QMA #5, on 9/14/17 at 9:20 a.m., she indicated Resident 5 refuses oral care and often	F 0280	Resident number 5's care plan was updated to reflect her current status. Her son helped with this update. All residents had the potential to be affected by this deficient practice. No others were found to be affected. All care plans will be reviewed and updated to reflect any changes. A book will be kept at the nurse's station for nurses to note any changes in the resident's mental or physical status. The book will be monitored weekly by the MDS Coordinator for 3 months, then monthly for 3 months, and quarterly by the QA Committee thereafter.	10/18/2017

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	refuses to the see the dentist. A dental visit note, dated 6/23/16, indicated Resident 5 was seen and a recommendation for a 6 month follow up was noted. A dental care plan, dated 7/12/17, indicated the following interventions, "...total care for mouth care and hygiene...arrange for dental consult yearly and as needed...." At 9:23 a.m., on 9/15/17, the Social Services Director indicated the resident often refuses dental services but if there were concerns the facility would make an appointment at the dental clinic down the street. The Social Services Director provided a Social Services note, dated 11/19/14, on 9/15/17 at 9:30 a.m. It indicated, "Resid [Resident] was et is not going to allow her teeth to be pulled. Her son is aware of the situation et states just keep her oral care up & and he will cont [continue] to discuss with her. D/T [Due to] severity of her dementia she's not capable of understanding...." On 9/15/17 at 10:16 a.m., CNA #1 indicated Resident #5 often refuses oral care and does not let anyone get near her			

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	mouth, including the dentist. During an interview with the MDS Coordinator, on 9/15/17 at 11:49 a.m., she indicated the Resident had progressed in her dementia and often refuses care, including oral care. I'm surprised a dentist was able to examine her last year, since she has a history of refusing other attempts at dental exams. The careplan should be updated to reflect her potential to refuse services and oral care. 1b. The MDS (minimum data set) assessment, dated 6/29/17, indicated Resident 5's vision was "...impaired-sees large print, but not regular print in newspapers/books...." During an interview with QMA #5, on 9/14/17 at 9:20 a.m., she indicated Resident 5 had glasses at one time, but would not wear them. A Nutrition Assessment, dated 6/29/17, indicated Resident 5 had glasses. An optometry visit dated 5/11/16, indicated no need for new glasses. A visual impairment care plan, dated 7/12/17, did not indicate an intervention related to glasses or refusal of wearing glasses.			

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At 10:15 a.m., on 9/15/17, CNA #1 indicated she had not seen Resident 5 with glasses on, but she would probably refuse to have them on. CNA #1 indicated she had not worked at the facility for very long.

The Social Services Director indicated, on 9/15/17 at 10:16 a.m., she was unsure where Resident 5's glasses were at the moment because Resident 5 kept taking them off and leaving them in different locations in the facility.

On 9/15/17 at 11:49 a.m., the MDS coordinator indicated Resident 5 refuses care and would not wear glasses if they were placed on her, so she will update the care plan to indicate Resident 5 chooses not to wear glasses.

The Social Services Director indicated, on 9/15/17 at 11:50 a.m., Resident 5's glasses were in her office with other resident's glasses.

An undated policy titled, Policy and Procedure for Updating Care Plans, was received from QMA #5 on 9/18/17 at 12:04 p.m. It indicated, "...Purpose: To ensure that the care plans are updated and reflect the resident's current status...The care plan will be updated when there is a

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	change in a resident's mental or physical condition. 2. The change should be noted and dated as soon as possible...The Social Service Director and the MDS Coordinator are responsible for updating care plans. 3.1-35(d)(2)(B)			
F 0282 SS=E Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the plan of care for medication administration, a 6 month routine dental evaluation, as recommended and to address pharmacy notifications for 2 of 11 residents observed during medication administration observation, 1 of 2 residents reviewed for dental status and services and 1 of 5 residents reviewed for unnecessary medications. (Residents 3, 6, 12 and 24)	F 0282	Resident numbers 3 & 12: An inservice was given to all nurses and QMA's concerning med pass, ordering medication, and documentation. All resident's med sheets were audited along with the medication cart to ensure that all ordered medications were available. All residents had the potential to be affected by this potential practice. We audited all med sheets and med carts to ensure that all medications were available as ordered. The med carts will be monitored by the charge nurses and QMA's before	10/25/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The clinical record for Resident 3 was reviewed on 9/14/17 at 10:45 a.m. The diagnoses for Resident 3 included, but were not limited to, encephalopathy, hypertension and debility. During a medication administration observation with QMA #5, on 9/14/17 at 9:20 a.m., QMA #5 was observed administering morning medications to Resident 3. Colace 100 milligrams (mg) was not one of the medication administered to Resident 3 at this time. A Physician's Order, dated 8/2/17, indicated to administer Colace 100 mg twice daily. There was no other documentation, including the Nurse's Notes and Physician's Orders, in the clinical record related to different dosing/timing of Colace since 8/2/17. During an interview and observation with QMA #5, on 9/15/17 on 10:04 a.m., she pulled out the Colace 100 mg medication card and 1 pill had been administered from the card. QMA #5 indicated the supply was not put in its usual location, so it was difficult to locate the new supply. The medication was not administered the previous day as it should've been.		they begin their daily med pass. This process will be monitored by the D.O.N. weekly, on an ongoing basis. The QA Committee will monitor this overall process on a quarterly basis to ensure that all ordered medications are available. This secondary monitoring by the QA Committee will be done continuously. Resident number 6: An appointment was scheduled by the Social Services Director. Resident number 6 was taken to the dentist. There were no new orders. The clinical record has been updated to show this appointment. All residents had the potential to be affected by this deficient practice. All resident's clinical records were audited to ensure that all dental appointments and referrals were scheduled in a timely fashion. The Social Services Director will keep a record book of all resident's dental appointments and referrals to ensure that no resident misses an appointment. All dental records will be monitored by the Social Services Director monthly and quarterly by the QA Committee, both on an ongoing basis. The QA Committee will use the SSD's appointment and referral book to ensure that all resident's appointments are being kept. Resident number 24: The prior approval was obtained	

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	155683	A. BUILDING 00 B. WING	09/18/2017

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	2. The clinical record for Resident 12 was reviewed on 9/14/17 at 10:47 a.m. The diagnoses for Resident 12 included, but were not limited to, hypertension, dementia and sleep apnea. During a medication administration observation with QMA #5, on 9/14/17 at 9:30 a.m., QMA #5 was observed administering morning medications to Resident 12. Refresh Liquidgel 1% eye drops was not one of the medication administered to Resident 12 at this time. QMA #5 indicated Resident 12's eye drops just ran out. A Physician's Order, dated 4/27/16, indicated to instill 1 drop of Refresh Liquigel 1% eye drops into each eye three times daily. There was no other documentation, including the Nurse's Notes and Physician's Orders, in the clinical record related to different dosing/timing of the eye drops. During an interview and observation with QMA #5, on 9/15/17 on 10:04 a.m., she pulled out the Refresh Liquigel 1% eye drops. The date 9/15/17 was written on the eye drop bottle. QMA #5 indicated the supply was not put in its usual location, so it was difficult to locate the new supply. The medication was not		from the Physician and the medication was ordered and given to resident number 24. A new policy over prior authorizations has been put in place. All residents had the potential to be affected by this deficient practice. All resident's charts were audited. There were no other orders for other prior authorizations found. A new policy on prior authorizations was put in place by the Administrator. An inservice over this new policy was given to all nurses and QMA's. A book containing all prior authorizations was placed at the nurse's station for daily review. This book will be monitored and signed on a daily basis by the charge nurses. The D.O.N. will monitor this process weekly and the QA Committee quarterly, both on an ongoing basis. The QA Committee will monitor the prior authorizations book and the new policy to determine their effectiveness and to ensure that all prior authorizations will be forwarded to the Physician as soon as they are obtained by the facility.	

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	administered the previous day as it should've been.3. The clinical record for Resident 6 was reviewed on 9/12/17 at 1:00 p.m. The diagnoses for Resident 6 included, but were not limited to, edentulous. An observation of Resident 6 was made on 9/12/17 at 1:13 p.m. He had no teeth or dentures in his mouth. An interview was conducted with Resident 6 on 9/12/17 at 1:05 p.m. He indicated he had problems with his teeth, gums, or dentures, and that staff was not taking care of this to his satisfaction. The 8/23/17 dental care plan indicated Resident 6 had no natural teeth or tooth fragments. An intervention was to arrange for a dental consult yearly and as needed. The 10/3/16 dental exam read, "Recommended Treatment Plan...Schedule: 6 Months - 180 Days Periodic." An interview was conducted with the SSD (Social Services Director) on 9/15/17 at 10:16 a.m. She indicated Resident 6 did not have a 180 day periodic evaluation, as recommended, after his 10/3/16 dental exam. She			

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	indicated, at the time, the facility was no longer using the same provider, and Resident 6 did not want to go to another provider. She reviewed Resident 6's clinical record, and indicated she did not document this anywhere. An interview was conducted with Resident 6 on 9/15/17 at 10:26 a.m. He indicated he was willing to see a dentist, but no one from the facility asked him about going, since his 10/3/16 dental exam. He indicated if he had been asked, he would have went. The Dental Services Policy was provided by the SSD on 9/15/17 at 1:57 p.m. It read, The facility will encourage residents to have routine prophylactic dental care to the extent resident personal or third party funds are available." 4. The clinical record for Resident 24 was reviewed on 9/13/17 at 9:56 a.m. The diagnoses for Resident 24 included, but were not limited to: depression and anxiety. The 7/31/17 antidepressant medication care plan indicated there was a potential for discomfort and side effects related to the use of an antidepressant. An intervention was to administer medication as ordered.			

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	The 8/8/17 Psychotherapy Progress Note read, "Patient was seen for psychotherapy for major depressive disorder....Chart records numerous recent incidents of behavioral disturbance including cursing at staff (7/12/17, 7/21/17, 8/4/17), refusing medication (7/21/17), noncompliance with diet (7/21/17, 7/28/17), and verbal aggression (8/4/17)....Target Symptoms and Current Severity (0-10) (0 = no symptoms, 10 = maximum severity): anxiety - 5, hypomania - 3, Inappropriate Behavior - 3, Depression - 3, Verbal Aggression - 5, Impulse Control Problem - 5....Current Psychotropic Medications: 1. Zoloft (antidepressant) - 150 mg -qam (every morning)....Recommendations for Attending Physician: 1) In view of depression with agitation, anxiety, and pain complex, and the tendency for SSRIs (selective serotonin reuptake inhibitors) to increase agitation in some patients with dementia, you may wish to consider the medical appropriateness of switching to an alternative antidepressant with anxiolytic and analgesic properties such as Cymbalta 60 mg qam for better control of depression with agitation, anxiety, and pain complex." The 9/1/17 Physician Order read, "...9/1/17 Start Cymbalta 30 mg PO (by			

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	mouth) QD (everyday) x (times) 7 days then 60 mg PO QD." The September, 2017 MAR (medication administration record) indicated Resident 24 did not receive 30 mg of Cymbalta for 7 days, as ordered, or begin taking 60 mg of Cymbalta everyday afterwards, as ordered. The 9/1/17 pharmacy notification, faxed to the facility on 9/1/17 at 5:04 p.m., indicated prior authorization was required for the Duloxetine (generic Cymbalta) 30 mg X 7 days. There was no information in the clinical record to indicate the pharmacy notification was addressed. The 9/8/17 pharmacy notification, faxed to the facility on 9/8/17 at 9:43 a.m., indicated prior authorization was required for the Duloxetine (generic Cymbalta) 60 mg QD, and that M.D. must call Medicaid to let them know the Zoloft was discontinued. There was no information in the clinical record to indicate the pharmacy notification was addressed. A telephone interview was conducted with Pharmacy Technician #2 on 9/14/17 at 2:24 p.m. She indicated they received the prescription for the Cymbalta on 9/1/17, and sent the facility a notice to			

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	inform them prior authorization was required, but they never heard anything back. The Physician Notification/Medication Availability policy was provided by QMA (Qualified Medication Aide) #5 on 9/18/17 at 12:04 p.m. It read, "When the medication is ordered and it is a medication that will not be paid by the resident's insurance or a private (sic) approval is needed, the physician should be notified immediately." 3.1-35(g)(2)			
F 0313 SS=D Bldg. 00	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or			

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	hearing assistive devices. Based on interview and record review, the facility failed to provide optometry services timely and address an order for eye drops for a resident with a history of glaucoma for 2 of 3 residents reviewed for vision. (Residents 3 & 16) Findings include: 1. The clinical record for Resident 3 was reviewed on 9/15/17 at 10:00 a.m. The diagnoses for Resident 3 included, but were not limited to, glaucoma. He was admitted to the facility on 1/3/17. An undated consent to receive vision services was provided by the SSD (Social Services Director) on 9/15/17 at 10:58 a.m. The 6/29/17 Quarterly MDS (minimum data set) assessment indicated Resident 3's vision was impaired, could see large print, but not regular print in newspapers/books, and did not use corrective lenses. The 4/4/17 Physician's Note read, "Pt (patient) does note h/o (history of) glaucoma for which he has not yet received his ophthalmic drops...." The 4/4/17 Physician's Order read, "Pt	F 0313	Resident number 3 was seen by the Optometrist on September 28, 2017. Resident number 16 will be seen on October 24, 2017. All residents had the potential to be affected by this deficient practice. All resident's records were reviewed and all residents have been scheduled to see the Optometrist on an annual basis or as needed. Copies of the Optometrist's lists of residents to be seen will be kept by the Social Services Director, and the Administrator, as well as in a record book to be placed at the nurse's station. The SSD will continuously monitor this list on a monthly basis to ensure that all residents have their appointments scheduled and are making those appointments. This process will be monitored by both the Social Services Director and the Administrator monthly on a continuous basis to ensure that all appointments are being kept. The QA Committee will monitor this overall process quarterly, on an ongoing basis, to ensure that this process is effective and that all resident appointments are being made and kept.	10/25/2017

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	has h/o glaucoma; please call (name of physician and phone number) (symbol for "with") names and dosing of eye drops ASAP (as soon as possible)." There was no information in the clinical record to indicate the above order was addressed or that Resident 3 received optometry services in the facility. An interview was conducted with the MDS Coordinator on 9/15/17 at 11:14 a.m. She reviewed Resident 3's clinical record, and indicated he needed to see optometry. An interview was conducted with the MDS Coordinator on 9/15/17 at 11:32 a.m. She indicated she did not see anything to indicate the 4/4/17 physician's order was addressed. An interview was conducted with the SSD (Social Services Director) on 9/15/17 at 10:56 a.m. She indicated Resident 3 had not received optometry services since he was admitted to the facility. She indicated, usually, residents were set up to be seen as soon as they were admitted, but the facility had no optometry provider. 2. The clinical record for Resident 16 was reviewed on 9/13/17 at 10:00 a.m. The diagnosis for Resident 16 included, but			

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	was not limited to: glaucoma. An Optometry Exam dated 10/5/16, indicated the treatment plan for Resident 16 was to have his next appointment scheduled in 6 months for a IOP (intraocular) check regarding his open-angle glaucoma diagnosis. An interview was conducted with the Social Services Director on 9/14/17 at 3:13 p.m. She reported residents' vision was checked annually. She stated Resident 16 had not been seen by an eye doctor since the October exam in 2016, but was scheduled to be seen this month. A vision policy was provided by the Qualified Medication Aide 5 on 9/18/17 at 12:04 p.m. It indicated, "...Policy: Each resident will be provided assistance in obtaining routine and emergency vision care. Purpose: To ensure that all residents receive adequate vision services. Procedure: 1. Residents are to be seen by an optometrist on an annual basis unless emergency services are required....3. Social Services will be responsible for ensuring that all residents are receiving vision services..." 3.1-39(a) 3.1-39(a)(1)			

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F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to			

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	treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on interview and record review, the facility administered insulin in excessive dosages to 1 of 5 residents reviewed for unnecessary medications. (Resident 21) Findings include: The clinical record for Resident 21 was reviewed on 9/13/17 at 9:52 a.m. The diagnoses for Resident 21 included, but were not limited to, diabetes mellitus. The September, 2017 Physician's Orders indicated to test Resident 21's blood sugar twice daily at 11:00 a.m. and 4:00 p.m., and to administer Humalog 100 Units/ML Per Sliding Scale as follows: 200 - 250 = 2 Units 251 - 300 = 4 Units 301 - 350 = 6 Units 351 - 400 = 8 Units The September, 2017 Fingerstick Record indicated the following blood sugar readings with the following Units of	F 0329	The Medical Director was immediately notified of the medication error. The resident was monitored for side effects from the medication. There were no untoward side effects to be found. All residents had the potential to be affected by this potential practice. All other finger stick sliding scales were audited. None were found to be incorrect. All nurses and QMA's were inserviced over the sliding scale and how to implement orders correctly. The D.O.N. will make out the finger stick sheets monthly. The charge nurses will implement any changes that occur during that month. The D.O.N. will observe all insulin given per sliding scale two times per week to ensure that the insulin given and sliding scale are correct. This will be done on an ongoing basis. This process will be monitored twice a week by the D.O.N. and then quarterly by the QA Committee, both on an ongoing basis. The QA Committee will monitor this process	10/25/2017

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	Humalog administered: 9/1/17 @ 12:00 p.m. = 200, no insulin given 9/1/17 @ 4:00 p.m. = 200, no insulin given 9/2/17 @ 12:00 p.m. = 224, no insulin given 9/2/17 @ 4:00 p.m. = 201, 4 Units given 9/3/17 @ 4:00 p.m. = 220, 4 Units given 9/5/17 @ 4:00 p.m. = 200, no insulin given 9/6/17 @ 4:00 p.m. = 201, 4 Units given 9/7/16 @ 12:00 p.m.= 250, 6 Units given 9/7/16 @ 4:00 p.m. = 200, no insulin given 9/8/17 @ 12:00 p.m. = 240, 4 Units given 9/9/17 @ 12:00 p.m. = 200, no insulin given 9/10/17 @ 4:00 p.m. = 200, no insulin given 9/11/17 @ 4:00 p.m. = 224, 4 Units given 9/12/17 @ 12:00 p.m. = 250, 6 Units given 9/12/17 @ 4:00 p.m. = 224, 4 Units given 9/13/17 @ 12:00 p.m. = 249, 4 Units given 9/14/17 @ 12:00 p.m. = 250, 6 Units given An interview was conducted with the DON (Director of Nursing) and MDS (minimum data set) Coordinator on 9/14/17 at 11:26 a.m. They reviewed		and the finger stick sheets to ensure its effectiveness and that the process is being followed.	

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	Resident 21's September, 2017 Fingerstick Record. The MDS Coordinator indicated it would be fixed. The Physician Notification/Medication Availability policy was provided by QMA (Qualified Medication Aide) #5 on 9/18/17 at 12:04 p.m. It read, "Purpose: To ensure that all residents receive their medications as ordered by the physician." 3.1-48(a)(1)			
F 0356 SS=C Bldg. 00	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview the facility failed to ensure daily nurse staffing was visibly posted for the residents. This had a potential to affect 23 of 23 residents in the facility. Findings include: Observations were made of the facility on the following days there was no nurse staff posting: 9/12/17 at 12:15 p.m.,	F 0356	A nursing schedule was posted on the wall near the main entrance in a spot that is visible to all that enter the facility. All had the potential to be affected by this deficient practice. A new policy was written on daily posting of all nursing schedules. The Nursing Department has been inserviced over this new policy by	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	09/18/2017

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	9/13/17 at 1:33 p.m., 9/14/17 at 2:25 p.m., 9/15/15 at 9:55 a.m., and 9/18/17 at 8:50 a.m. An observation was made of the staff posting with the Administrator on 9/18/17 at 9:30 a.m. He indicated staffing was posted by the time clock, that was located in a hallway with a closed door for the staff. The Administrator stated the staff posting was not posted anywhere else in the facility visible for the residents. An interview was made with the the Administrator on 9/18/17 11:06 a.m. He reported he did not have a policy regarding staff posting.		the D.O.N. The D.O.N. will be responsible for creating this schedule and will be responsible for posting it unless not working that day. In which case, the day charge nurse will post the schedule. This process will be monitored daily by the D.O.N. to ensure that the nursing schedule is always placed and visible. This monitoring will be done daily on an ongoing basis. The Administrator will serve as a secondary check as he will also monitor this process daily on an ongoing basis. In the event that the Administrator or D.O.N. are not in the facility on a given day, it is the responsibility of the day charge nurse to ensure that the nursing schedule is visibly posted. The monitoring of this process will be a continuous process.	
F 0431 SS=D Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide			

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	pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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			

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	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 destroy medication in a timely manner for 1 of 1 medication storage rooms observed. Findings include: During an observation with the QMA #5 on 9/18/17 at 10:21 a.m., a medication punch card for haldol (anti-psychotic) 5 milligrams was observed in the cabinets above the sink. The punch card indicated to discard the medication 10/2015. The punch card wasn't in close proximity to other medications that were to be destroyed. The identifying information (resident name or date of birth) on the punch card was cut off of the card. At 10:31 a.m., on 9/18/17, the Director of Nursing (DON) indicated she was unsure why the medication was in cabinet and why the identifying information was cut off of the card. She indicated she was unsure whom the medication belonged to and she will destroy the punch card. The DON indicated at 10:55 a.m., on 9/18/17, the facility destroys medication 30-60 days after a resident discharges and	F 0431	The medication room and medication cart were checked for all discontinued medications. All medications that had been discontinued were immediately destroyed. All residents had the potential to be affected by this deficient practice. All medication carts and the medication room were checked for discontinued medications. None were found. A new policy on medication destruction was written by the Administrator. An inservice over this new policy was given to all nurses and QMA's. The new policy calls for discontinued medications to be destroyed within 7 days. A new book containing copies of all discontinued medications will be kept at the nurse's station. This book, the medication cart, and medication room will be monitored every Monday by the charge nurse and/or D.O.N. on a continuous basis to ensure that the discontinuance of all medications has been documented and all discontinued medications are destroyed in a timely fashion. The QA Committee will monitor this overall process on a quarterly basis to determine its	10/25/2017

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	the medication should've been destroyed over a year and half ago. A policy titled, Policy and Procedure for the Destruction of DC'd Medication, no date, was received from QMA #5 on 9/18/17 at 12:04. The policy indicated, "...When a resident is discharged, their medication will be destroyed within 30-60 days. 2. When a medication itself is DC'd, it will be destroyed within 7 days. 3. All DC'd medication will be placed within the Medication Room for destruction...." 3.1-25(o) 3.1-25(r)		effectiveness and to ensure that all discontinued medications are disposed of in a timely fashion.	