STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. BUILDING 00 B. WING	02/23/2016

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LAKELAND REHABILITATION AND HEALTHCARE CENTER	505 W 4TH ST MILFORD, IN 46542

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 15, 16, 17, 18, 19, 22, and 23, 2016 Facility number: 000491 Provider number: 155495 AIM number: 100291230 Census bed type: SNF: 10 SNF/NF: 42 Total: 52 Census payor type: Medicare: 8 Medicaid: 35 Other: 9 Total: 52 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on March 1, 2016.	F 0000	Preparation or execution of this plan of correction by Lakeland Rehabilitation and Healthcare does not constitute an admission or agreement of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in response to the allegations of noncompliance cited during the Annual Recertification and State Licensure Survey on February 23, 2016. Please accept this Plan of Correction as the provider's credible allegation of compliance.	
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on interview and record review, the facility failed to assess a resident following a change in bladder status for 1 of 3 residents reviewed for incontinence. (Resident #29) Findings include:	F 0272	1. Resident #29 had a bladder re-assessment completed. 2. Current residents MDS's reviewed for change in bladder staus. 3. MDS Coordinator has been re-inserviced to notify Director of Health Services/designee when a change in bladder status is noted	03/24/2016

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	02/18/2016 at 4:22 P.M. the clinical record for Resident #29 was reviewed. Resident #29 was admitted on 12/26/2015. The diagnoses included, but were not limited to: kidney failure, enlarged prostate without lower urinary tract symptoms, Parkinson's disease and dementia without behavioral disturbance. An MDS (Minimum Data Set) assessment, dated 11/15/2015, indicated Resident #29 had a change in bladder status from occasionally incontinent to frequently incontinent. There was no documentation in the record to indicate a bladder assessment was completed following Resident #29's change in status. During an interview on 2/23/2016 at 1:38 P.M., the DON (Director of Nursing)indicated that she was unaware of why Resident #29 went from occasionally incontinent to frequently incontinent and there was not a bladder assessment completed following the status change. She further indicated that it was her practice to complete an assessment when a resident experiences a status change. During an interview on 2/23/2016 at 2:30		to complete a bladder re-assessment. Licensed nurses have been re-inserviced on bladder guidelines. 4. Director of Health Services/designee will audit 5 residents MDS per week to ensure any change in continence status is reflected and a bladder re-assessment will be completed on residents with change in bladder status. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to Plan of Correction as needed.	

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	P.M., the MDS coordinator indicated that she did not notice a change in Resident #2 status because she wasn't here for the previous MDS. She indicated the staff did not notice a change and that when a change has been found on an MDS, the resident is medically evaluated and an assessment is completed to see why the resident has experienced a decline. A policy was provided by the Corporate Nurse on 2/23/2016 at 1:15 P.M., titled "Bowel and Bladder Continence," undated, and indicated this was the current policy used by the facility. The policy indicated "...PROCEDURE: Complete a bowel and bladder assessment as part of the admission nursing assessment and implement care plan interventions as appropriate...." 3.1-31(a)			
F 0279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes			

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	measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interviews, the facility failed to ensure 3 of 3 residents (Residents #26, #55 and #61) admitted with a risk of developing pressure areas had care plan interventions implemented to reduce the risk of pressure ulcer development. In addition, the facility failed to ensure a 1 of 5 residents reviewed for unnecessary medications had a care plan implemented timely to address his medical symptom of delusions. (Resident #54) The facility also failed to implement a care plan to address incontinence needs for 1 of 2 residents reviewed for incontinence. (Resident #8) Finding includes: 1. The clinical record for Resident #26 was reviewed on 02/18/2016 at 11:19 A.M. Resident #26 was admitted to the	F 0279	1. Residents #26, #55, #61, #8, and #54 care plans were updated to reflect care being delivered. 2. Current residents care plans have been reviewed for risks of developing pressure ulcers and interventions in place to reduce risk of pressure ulcer development, residents with delusions and residents with incontinence. 3. MDS Coordinator and Nursing Admin team have been re-inserviced on care plan guidelines. 4. Director of Health Services/designee will audit 5 residents careplans per week to ensure care plans are reflective of the care being delivered. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	03/24/2016

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	facility on 06/22/15. The diagnoses, included, but were not limited to: Parkinson's disease, epilepsy with simple partial seizures, anorexia nervosa, aphasia, cerebrovascular disease and muscle weakness. The admission nursing assessment, completed on 06/22/15, indicated the resident had no pressure areas or skin conditions when he was admitted. The initial MDS (Minimum Data Set) assessment, completed on 06/30/15, indicated the resident required extensive staff assistance for bed mobility and transfer needs, was non-ambulatory and was frequently incontinent of his bowels and bladder. The resident was at risk for pressure ulcer development. The assessment indicated pressure ulcers had triggered as an area to care plan. A Monthly nursing assessment, completed on 07/23/16, indicated the resident had no skin areas or issues and did not require a plan of care related to skin. A skin impairment circumstance investigation form, dated 09/02/15, indicated the resident had developed a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a			

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	red pink ulcer bed without slough. May also present as an intact blister or open/ruptured serum filled blister.) pressure ulcer on his coccyx. The form indicated it was possibly caused by moisture and pressure as the head of his bed was elevated due to his tube feeding. After the development the interventions were to make sure he had appropriate treatment, reposition/offset pressure with pillows, encourage resident to lay down between meals and a wheelchair cushion. A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, initiated on 09/02/15, indicated one of the pressure ulcer wounds was located on his upper coccyx, was 1 cm (centimeter) by 0.3 cm, depth was undetermined and was pink in color. The treatment was Calazyme (skin protectant) every shift. The wound was documented as healed on 09/08/15. A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment indicated, on 09/02/15, a Stage 2 pressure ulcer on the lower coccyx. The wound was 4 cm by 1 cm and and of undetermined depth. The wound was red and the treatment was calazyme every shift. The wound was documented as healed on 10/06/15. A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, indicated a wound had			

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	been initially identified, on 11/30/15, as a Stage 2 pressure ulcer on the upper sacrum of Resident #26. The wound was 1 cm by 1 cm with no depth and was cleansed with A and D ointment. The charting on 12/01/15 indicated "Merged with other sacral wound." Another Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, indicated a Stage 2 pressure wound had been initially identified, on 11/30/15, on the lower sacral area. The wound was 1 cm by 1 cm and was cleansed with A and D ointment (Skin Protectant). There was no documentation to indicate care plans were developed and implemented to prevent further pressure ulcer development until 12/11/15. The pressure ulcer for Resident #26 was observed on 02/19/2016 at 11:02 A.M. with the Assistant Director of Health Services LPN (Licensed Practical Nurse) #20. The resident had a small 1 inch by 1/3 inch football shaped wound on his lower coccyx area. He had a pink slightly open area off to the right side of the wound that had almost healed. LPN #20 indicated the wound had very little exudate and had really improved. 2. The closed clinical record for Resident			

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	#55 was reviewed on 02/22/2016 at 11:23 A.M. Resident #55 was admitted to the facility on 10/02/15, with diagnoses, including but not limited to: diabetes, MRSA (Methicillin-resistant Staphylococcus aureus), esophageal cancer, hypertension, acid reflux and dysphagia. The nursing admission assessment, completed on 10/02/16, indicated the resident had no pressure areas. There was no care plan implemented and no interventions documented as implemented to prevent pressure ulcers or risk for developing impaired skin. The initial MDS (Minimum Data Set) assessment, completed on 10/09/15, indicated the resident was at risk for pressure ulcer development and had one Stage 1 (Intact skin with nonblanchable redness of a localized area, usually over a boney prominence.) pressure ulcer. The resident required extensive staff assistance for mobility, transfers and dressing. The resident was occasionally incontinent of bladder. A 10/08/15 Skin Impairment Circumstance, Assessment and Intervention form, completed on 10/09/15, indicated the resident had developed a Stage one pressure ulcer on			

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	the left buttocks. The form indicated the resident had pressure relief devices (unspecified), a care plan, and consumed adequate nutrition, The resident's pressure ulcer increased to a Stage 2 pressure ulcer, on 10/13/15, and the treatment was changed to A and D ointment every shift. The resident's wound healed on 10/27/15. A Skin Impairment Circumstance, Assessment and Intervention form, initiated on 11/11/15, indicated the resident had developed Stage 2 pressure areas on his right and left buttocks. The form indicated a hydrogel gauze and foam dressing was ordered. The form also indicated the resident had pain and was noncompliant with positioning devices as he refused a recliner cushion. A clinically at risk individual monitoring sheet, imitated on 11/11/15, indicated on the weekly follow up assessment the wound was worsening and was 4 cm by 1 cm on the right buttocks and was 5 cm by 4 cm on the left buttocks. The form indicated both wounds were healed on 12/21/15. The resident was discharged to the hospital on 11/20/15, and there were no open areas or skin issues designated on the transfer form.			

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	The resident was readmitted to the facility on 11/21/15, and had an old scar from a healed pressure ulcer but no other skin issues. The assessment review and considerations form, completed on 10/26/15 (sic), indicated the resident had impaired mobility which put him at risk for skin breakdown The resident was discharge to an acute care center on 11/25/15 and readmitted on 11/26/15. The nursing readmission assessment, completed on 11/26/15 indicated a circle located on the coccyx of the body diagram and "open area" was written on the assessment form. There was no assessment of the circled "open area" marked on the readmission nursing assessment completed on 11/26/15. There was no care plan implemented or interventions to prevent pressure ulcers until 12/11/15, after the resident had developed pressure areas 3 different times. During an interview with RN #1, a corporate nursing consultant, on 02/22/16 at 11:00 A.M. she indicated it was a "nursing standard of care" to turn and reposition all residents and the corporation's bed mattresses were all pressure relieving mattresses and some kind of cushion was placed in all			

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	wheelchairs even if the interventions were not documented. She indicated there were specific interventions implemented on the purple colored wound assessment and tracking forms after the wounds developed. She also indicated care plans were not implemented until day 21 of the resident's stay at the facility. 3. The clinical record for Resident #54 was reviewed on 02/18/2016 at 2:06 P.M. Resident #54 was admitted to the facility, on 11/13/14, with diagnoses, including but not limited to: cellulitis, history of falls, right hip fracture, dementia, osteoarthritis, hypertension, glaucoma, insulin dependent diabetes mellitus, and peripheral neuropathy. The current physician's orders for medications for Resident #54 included Seroquel 75 mg (milligrams) q (every) has (hour of sleep) (reduced 01/15/16) for dementia with delusions. The care plan for Resident #54, presented on 02/15/16 at 3:00 P.M. indicated there was no plan to address the residents diagnosis of delusions. The mood and behavior care plan addressed his depression, anxiety, and dementia with behavioral disturbances, but there was no explanations of what target symptoms			

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	were to be monitored and the only interventions were to administer medications , monitor the medications for adverse side effects, and notify the physician of any adverse side effects. 4. A clinical record was completed on 2/22/2016 at 11:00 A.M., for Resident #61 and indicated Resident #61 was admitted on 9/9/2015. The diagnoses included but were not limited to: hypertension, diabetes mellitus and coronary artery disease. Resident #61's ICARE (a care plan that is written in first person) did not indicate any skin risk interventions. A "SKIN IMPAIRMENT CIRCUMSTANCE ASSESSMENT AND INTERVENTION" form, dated 9/28/2015, indicated Resident #61 developed two stage two pressure ulcers. During an interview on 2/22/2016 at 12:37 P.M., the corporate nurse indicated that the facility does not provide CNA (certified nursing assistant) careguides. She further indicated that the CNAs would find the information they needed from the ICARE plans. During an interview on 2/22/2016 at 12:50 P.M., CNA (certified nursing			

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	assistant) #2 indicated she would go to the facilities ICARE plans to find out how to provide care to residents. A "Nursing Admission Assessment and Date Collection" form indicated "...Turn and reposition....", "...use lift sheet to reposition in bed....", and "...Ensure resident is clean and dry...." A policy provided by the corporate nurse on 2.23.2016 at 1:15 P.M., titled "...PRESSURE PREVENTION GUIDELINES..." and indicated this was the current policy used by the facility. The policy indicated "...Procedure: Careplan interventions shall be implemented based on risk factors identified in the nursing assessment...." 5. A clinical record review was conducted for Resident #8 on 2/18/2016 at 2:42 P.M., and indicated he was admitted on 9/2/2015. The diagnoses included, but were not limited to: pathological fracture left fibula, difficulty in walking, muscle weakness, history of falling, constipation and hyperlipidemia. The MDS (Minimum Data Set) assessment, dated 9/21/2015, indicated Resident #8 should have a care plan addressing his incontinence needs.			

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	The MDS (Minimum Data Set) assessment, dated 12/11/2015, indicated Resident #8 had a decline in incontinence status from never incontinent to occasionally incontinent. The was no documentation to indicate the care plans had any interventions related to Resident #8's need for assistance to the restroom. During an interview on 2/22/2016 at 9:44 A.M., the MDS coordinator indicated the residents CAAs (Care Area Assessment) summary triggered for a bowel and bladder care plan and that he should have a care plan directing the staff to assist him to the restroom. During an interview on 2/22/2016 at 3:00 P.M., the corporate nurse indicated Resident #8 should have a "ELIMINATION CIRCUMSTANCE REASSESSMENT AND INTERVENTION" form with his assessment in his chart. She further indicated Resident #8 did not have this form. The facility policy and procedure titled, "Interdisciplinary Team Care Plan Guidelines, revised on 06/15, and provided by RN #1 on 02/22/16 at 3:30 P.M. included the following: "a. The			

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LAKELAND REHABILITATION AND HEALTHCARE CENTER	505 W 4TH ST MILFORD, IN 46542

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	initial plan of care included on the Admission Nursing Assessment will be initiated within 24 hours and completed within 72 hours of admission to address pertinent areas, treatment, and risk. i.Care plan interventions should be reflective of the impact the risk area(s) disease process(es) have on the individual resident...." 3.1-35(a) 3.1-35(b)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a physician's order was followed for 1 of 3 residents reviewed for unnecessary medications. (Resident #33) Finding includes: On 2/18/2016 at 2:42 P.M., a clinical record review was completed for Resident #33. Resident #33 was	F 0282	1. Resident #33s dose was updated to reflect the physicians order. 2. Current residents physician orders have been reviewed to ensure accuracy of dosage of medication. 3. Licensed nurses have been re-inserviced to ensure accuracy of medication orders are noted when orders are obtained or clarified. 4. Director of Health Services/designee will audit 5 residents medication orders weekly during Clinical Care	03/24/2016

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	admitted on 4/15/2015. The diagnoses, included but were not limited to: dementia without behavioral disturbance and major depressive disorder recurrent severe without psychotic features. A physician's order, dated 7/7/2015, indicated Resident #33 was ordered Seroquel (an antipsychotic medication) 25 mg (milligrams) every morning and Seroquel 50 mg every night. A "Note to Attending Physician/Prescriber" indicated that nursing assessments and social service notes did not reflect any delusions or hallucinations since a dose reduction on 7/7/2015, and recommended Seroquel to be decreased to 25 mg twice a day. The form indicated the physicians response was "Agree." A physician order, dated 10/26/2015, indicated Resident #33 was ordered Seroquel 25 mg twice a day. Resident #33's MAR (Medication Administration Record) for November 2015 indicated Resident #33 had been administered Seroquel 25 mg every morning and 50 mg every evening for the month of November 2015. During an interview on 2/22/2016 at 2:00		Meeting to ensure accuracy of medication orders. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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	P.M., the Corporate Nurse indicated Resident #33 should have been taking Seroquel (an antipsychotic medication) 25 mg twice a day after 10/26/2015, and not taking Seroquel 25 mg in the morning and 50 mg at night. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary 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. Based on record review and interview, the facility failed to thoroughly and accurately assess surgical incisions and implement timely interventions for 1 of 2 residents reviewed for hospitalization. (Resident #62) Finding includes: On 2/23/16 at 9:18 A.M., record review indicated Resident #62 was admitted to the facility on 10/9/15, and discharged to the hospital on 10/30/15, with diagnoses including, but not limited to, "...motor	F 0309	1. Resident #62 was discharged. 2. Current residents with surgical incisions have been assessed to ensure proper interventions for healing are in place. 3. Licensed nurses have been re-inserviced on assessing surgical sites and notification of MD to treat surgical sites if surgical site has signs and symptoms of infection. 4. Director of Health Services/designee will audit 5 residents weekly to ensure surgical sites are accurately assessed. DHS/designee will report findings to QA&A for 6 months or until 100% compliance	03/24/2016

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	vehicle accident, left hip fracture, right total knee replacement and right elbow fracture...." An admission nursing assessment, dated 10/9/15, indicated patient has a post-op incision to L (left) knee with steri strips (skin closures) without drainage. Patient also has a bandage to L buttock. The care plan, dated 10/12/15, with no revision date, indicated the problem: Skin: I have had 2 joint replacements following a motor vehicle accident. Please monitor my incision sites and contact my physician with any changes. The admission MDS (Minimum Data Set) assessment, dated 10/16/15, indicated the resident required extensive 2 person assistance with bed mobility, transfers, dressing and personal hygiene. The MDS assessment indicated the resident has a hip fracture with a surgical wound and requires surgical wound care. Skilled Charting Evaluation, dated 10/19/15, indicated the following: dressing to L hip dry and intact. No incisional drainage. Temperature 98.0 degrees Fahrenheit (F). Pain to L leg throbbing. Skilled Charting Evaluation, dated		is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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	10/20/15, indicated the following: incision with steri-strips intact, new dressing to hip intact, no incisional drainage. Temperature 97.0 degrees (F). Skilled Charting Evaluation, dated 10/21/15, indicated the following: incision with steri strips intact, dressing intact to hip. Incisional drainage none. Temperature 97.9 degrees (F). Pain to left hip and right knee moderate. A facility form (for physician notification), dated 10/21/15, indicated resident exhibits slight swelling with redness and warmth L knee incision. Resident afebrile at this time and has had no complaints of pain. Located at the bottom of the form was a place for a physician response, the line was blank. There was no indication on the form that it was faxed to the physician. A nurse note, dated 10/21/15 at 2:30 P.M., indicated resident exhibits swelling redness with warmth L knee incision. Notification of surgeon endorsed to following day shift when surgeon available. Skilled Charting Evaluation, dated 10/22/15, indicated the following: incisional drainage none. There was no documentation regarding the surgical			

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	wounds or dressings. Pain to R knee throbbing. Skilled Charting Evaluation, dated 10/23/15, indicated the following: there was no temperature documented, no documentation regarding incisional drainage and no documentation regarding the surgical wounds or dressings. Skilled Charting Evaluation, dated 10/28/15, indicated the following: incisional drainage none. There was no documentation regarding the surgical wounds or the dressings. Pain L lower leg throbbing. A nurse note, dated 10/29/15 at 10:30 A.M., note opening at proximal end of surgical incision. 1.4 centimeter long, draining serous drainage, redness and warmth noted along incision line, bright red and hardness noted around open area. Resident denies increase in pain. Temperature 101.3 degrees (F). 10:45 A.M. (physician name) notified new order received Rocephin (an antibiotic) 1 gram intramuscular for 7 days. First dose given. Ortho doctor notified. Appointment scheduled today at 2:25 P.M. Family and resident aware. Temperature 101.7 (F). Medicated with Tylenol (for mild pain or fever) grains 10 orally. 4:30 P.M. Resident returned from			

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	appointment at (orthopedic office) new order received. Start Cipro (an antibiotic) 500 mg (milligrams) 1 orally 2 times daily for 7 days for surgical wound L hip. New order resident to see doctor at orthopedic office on 10/30/15 at 10:00 A.M. facility to transport. A nurse note, dated 10/30/15 at 11:00 A.M., indicated call received resident admitted to hospital straight from doctor's appointment. During an interview on 2/23/16 at 2:00 P.M., the Director of Nursing indicated if the nurse is seeing redness or drainage from a wound it would be her expectation to call the physician. She indicated she would expect the nurse to document on each surgical incision and dressings in the daily Medicare/skilled charting. During an interview on 2/23/16 at 2:15 P.M., RN (Registered Nurse) #1 indicated the nurse should document for signs and symptoms of infection to a surgical incision and the status of a dressing daily in the skilled charting and on the treatment sheet. A discharge summary, dated 11/25/15, indicated the patient had three major injuries requiring surgical intervention. One of those was her left hip revision.			

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	Approximately 6 weeks post status that surgery she presented to the office with purulent drainage. She was directly admitted to the hospital for urgent left hip incision, drainage, irrigation and excisional debridment. This healed slowly and required a wound vac until 11/18, when the wound dehisced and was open. 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interviews, the facility failed to ensure the fingernails were clean and trimmed for 1 of 3 residents reviewed for activities of daily living. (Resident #54) Finding includes: The clinical record for Resident #54 was reviewed on 02/18/2016 at 2:06 P.M. Resident #54 was admitted to the facility, on 11/13/14, with diagnoses, including but not limited to: cellulitis, history of	F 0312	1. Resident #54 nails were trimmed and clean. 2. Current residents have had their fingernails cleaned and trimmed. 3. Nursing staff have been re-inserviced to ensure residents fingernails are clean and trimmed during ADL care. 4. Director of Health Service/designee will audit 5 residents weekly to ensure fingernails are clean and trimmed. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make	03/24/2016

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	falls, right hip fracture, dementia, osteoarthritis, hypertension, glaucoma, insulin dependent diabetes mellitus, and peripheral neuropathy. Resident #54 was observed on 2/17/2016 at 09:27 A.M., seated in his wheelchair. His fingernails were long and there was a brown substance on the nail beds and underneath some of his fingernails. During an interview on 02/16/2016 at 2:32 P.M., the representative for Resident #54 indicated Resident #54's fingernails were often dirty and were not trimmed. She indicated at times she had brought in fingernail clippers and tried to trim his nails. She indicated she had also voiced her concerns regarding the fingernails to staff. Resident #54 was observed, on 02/18/16 at 9:30 A.M., in his wheelchair in the South lounge. His nails were still noted to be long and only the left thumbnail was noticeably dirty with a dark brown substance. Resident #54 was observed, on 02/22/2016 at 9:41 A.M., the south hallway in the lounge in his wheelchair, dressed. He had long, slightly jagged nails with some orange colored substance around the edges.		recommendations as needed.	

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The most recent Minimum Data Set (MDS) assessment for Resident #54, completed on 12/03/15, indicated he was severely cognitively impaired and required extensive staff assistance of two staff for personal hygiene needs and was totally dependent on staff for bathing needs.

The care plan for Resident #54, provided on 02/15/16, indicated the resident was to have set up assistance and cues for grooming and hygiene needs. There was also an undated plan which indicated the resident had scratches to his lower extremities. An intervention to the plan was to keep the resident's nails trimmed.

During an interview on 02/22/16 at 11:15 A.M., RN (Registered Nurse) #1 indicated the need to trim nails was to be checked weekly and was usually coordinated with a weekly manicure activity.

During an interview on 02/22/16 at 1:30 P.M., LPN (Licensed Practical Nurse) #22 indicated nails were checked by the nursing assistants with showers/baths and also the activity staff checked them on Wednesday manicures. She confirmed only licensed nurses were to trim the fingernails of diabetic residents. She

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	indicated the nursing assistants or the activity staff were to let the nurse know if nails needed to be trimmed. She indicated no one had notified her of the need to trim the fingernails of Resident #54. The current policy and procedure, titled "Nails, Care of (Finger and Toe), undated and provided by RN (Registered Nurse) #1 on 02/22/16 at 10:30 A.M., indicated a procedure for cleaning, trimming, and filing resident's fingernails. The policy indicated licensed nurses were the only staff who were to trim the nails of diabetic residents. There was no frequency for the nail care denoted on the policy. 3.1-38(a)(3)(E)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure			

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	sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interviews, the facility failed to ensure 3 of 3 residents admitted with risk of developing pressure areas had interventions implemented to reduce the risk of pressure ulcer development. This deficient practice resulted in the development of pressure ulcers, one of which became infected and required antibiotic treatment. (Residents #26, #55 and #61) Finding includes: 1. The clinical record for Resident #26 was reviewed on 02/18/2016 at 11:19 A.M. Resident #26 was admitted to the facility on 06/22/15, with diagnoses, including but not limited to: Parkinson's disease, epilepsy with simple partial seizures, anorexia nervosa, aphasia, cerebrovascular disease and muscle weakness. The admission nursing assessment, completed on 06/22/15, indicated the resident had no pressure areas or skin conditions when he was admitted. The initial MDS (Minimum Data Set) assessment, completed on 06/30/15,	F 0314	1. Resident #55 and #61 are discharged. Resident #26 was re-assessed for risk of developing further pressure areas and worsening of current pressure area and interventions implemented. Careplan updated to reflect residents current status.2. Current residents have been re-assessed for risk of developing pressure areas and interventions in place for prevention of developing pressure areas. New admissions/re-admissions will be assessed for risk of development of pressure area and interventions in place for prevention. 3.Licensed nurses have been re-inserviced to assess for risk factors for development of and/or worsening of pressure areas including implementation of interventions to prevent development or worsening of pressure areas. Careplans are updated to reflect resident current status. 4. DHS/designee will audit 5 residents weekly to ensure risk factors are identified and interventions are in place to prevent new areas from developing or worsening areas getting worse. DHS/Designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for	03/24/2016

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	indicated the resident required extensive staff assistance for bed mobility and transfer needs, was non-ambulatory, was frequently incontinent of his bowels and bladder. Resident #26 was at risk for pressure ulcer development. The assessment indicated pressure ulcers had triggered as an area to care plan. A Monthly nursing assessment, completed on 07/23/16, indicated the resident had no skin areas or issues and did not require a plan of care related to skin. A Skin Impairment Circumstance Investigation form, completed on 09/02/15, indicated the resident had developed a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact blister or open/ruptured serum filled blister.) pressure ulcer on his coccyx. The form indicated it was possibly caused by moisture and pressure as the head of his bed was elevated due to his tube feeding. After the development the interventions were to make sure he had appropriate treatment, reposition/offset pressure with pillows, encourage resident to lay down between meals and a wheelchair cushion.		any trends and make recommendations as needed.	

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	The Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, initiated on 09/02/15, indicated one of the pressure ulcer wounds was located on his upper coccyx, was 1 cm (centimeter) by 0.3 cm, depth was undetermined and was pink in color. The treatment was Calazyme (a skin protectant) every shift. The wound was documented as healed on 09/08/15. There was another Pressure/Stasis/Arterial/Diabetic Ulcer Assessment, also indicated on 09/02/15 for a Stage 2 pressure ulcer on the lower coccyx. The wound was 4 cm by 1 cm and and of undetermined depth. The wound was red and the treatment was calazyme every shift. The wound was documented as healed on 10/06/15. A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, indicated a wound had been initially identified, on 11/30/15, as a Stage 2 pressure ulcer on the upper sacrum of Resident #26. The wound was 1 cm by 1 cm with no depth and was cleansed with A and D ointment (a skin protectant). The charting on 12/01/15, indicated "Merged with other sacral wound." Another Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, indicated a Stage 2 pressure wound had been initially			

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	identified, on 11/30/15, on the lower sacral area. The wound was 1 cm by 1 cm and was cleansed with A and D ointment. The pressure ulcer assessment and tracking form indicated, on 12/01/15, the treatment was changed to hydogel gauze and opti foam wound dressing changed daily. Other interventions implemented were to turn and reposition with pillows in bed, wheelchair cushion in wheelchair and lay down between meals. On 12/07/15, a culture of the resident's sacral wound was ordered due to "slough" in the wound bed. The pressure ulcer assessment and tracking form indicated, on 12/09/15, the wound had a 0.1 centimeter depth and was a Stage 3 (Full thickness tissue loss) pressure ulcer. On 12/13/15, the physician ordered the antibiotic, Rocephin to be administered intramuscularly by injection due to the wound infection. On 12/14/15, the physician ordered the antibiotic, Levaquin to be given per the resident's gastrostomy tube for 10 days to treat the resident's sacral wound infection.			

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LAKELAND REHABILITATION AND HEALTHCARE CENTER	505 W 4TH ST MILFORD, IN 46542

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	On 12/22/15, the pressure ulcer assessment and tracking form indicated the Stage 3 pressure ulcer had increased in size and had "slight moisture" drainage. The treatment was changed to puracol (collagen dressing) and mepilex (foam dressing). On 01/03/16, a protein supplement was added to the resident's nutritional regimen. On 01/26/16, a low air loss mattress was added to the resident's bed. The pressure ulcer for Resident #26 was observed on 02/19/2016 at 11:02 A.M. with the Assistant Director of Health Services, LPN (Licensed Practical Nurse) #20. Resident #26 had a small, approximately 1 inch long by 1/3 inch football shaped wound on his lower coccyx area. He had a pink slightly open area off to the right side of the wound that had almost healed. LPN #20 indicated there was very little exudates and the wound had really improved. 2. The closed clinical record for Resident #55 was reviewed on 02/22/2016 11:23 A.M. Resident #55 was admitted to the facility, on 10/02/15, with diagnoses, including but not limited to: diabetes, methacillin - resistant staph aurous			

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	infection (MRSA), esophageal cancer, hypertension, acid reflux and dysphasia. The nursing admission assessment, completed on 10/02/16, indicated the resident had no pressure areas. There was no care plan implemented and no interventions documented as implemented to prevent pressure ulcers. The initial MDS assessment, completed on 10/09/15, indicated the resident was at risk for pressure ulcer development and had one stage one pressure ulcer, required extensive staff assistance for mobility, transfers, and dressing and was occasionally incontinent of bladder. A 10/08/15 Skin Impairment Circumstance, Assessment and Intervention form, completed on 10/09/15, indicated the resident had developed a Stage 1 (Intact skin with nonblanchable redness of a localized area, usually over a bony prominence.) pressure ulcer on his left buttocks. The form indicated the resident had pressure relief devices (unspecified), a care plan, and consumed adequate nutrition. The resident's pressure ulcer was documented to have increased to a Stage 2 pressure ulcer on 10/13/15, and the treatment was changed to A and D ointment every shift. The resident's wound healed on 10/27/15.			

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A Skin Impairment Circumstance, Assessment and Intervention form, initiated on 11/11/15, indicated the resident had developed Stage 2 pressure areas on his right and left buttocks. The form indicated a hydrogel gauze and foam dressing was ordered. The form also indicated the resident had pain and was noncompliant with positioning devices as he refused a recliner cushion.

A clinically at risk individual monitoring sheet, initiated on 11/11/15, indicated on the weekly follow up assessment the wound was worsening and was 4 cm by 1 cm on the right buttocks and was 5 cm by 4 cm on the left buttocks. The form indicated both wounds were healed on 12/21/15.

The resident was discharged to the hospital on 11/20/15 and there were no open areas or skin issues designated on the transfer form, even though the resident had open areas on both his right and left buttocks.

The resident was readmitted to the facility on 11/21/15 and had an old scar from a healed pressure ulcer but no other skin issues even though the resident's pressure ulcers, noted on 11/11/16, were not documented as healed until 12/21/15.

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	The assessment review and considerations form, completed on 10/26/15 (sic) indicated the resident had impaired mobility which put him at risk for skin breakdown. The resident was discharge to an acute care center on 11/25/15 and readmitted on 11/26/15. The nursing readmission assessment, completed on 11/26/15 indicated a circle located on the coccyx of the body diagram and "open area" was written on the assessment form. There was no assessment of the circled "open area" marked on the readmission nursing assessment completed on 11/26/15. There was no care plan implemented or interventions to prevent pressure ulcers until 12/11/15, after the resident had developed pressure areas 3 different times. During an interview on 02/22/16 at 111:00 A.M., RN (Registered Nurse) #1, a Corporate Nursing Consultant, indicated it was a "nursing standard of care" to turn and reposition all residents and the corporation's bed mattresses were all pressure relieving mattresses and some kind of cushion was placed in all wheelchairs even if the interventions were no documented. She indicated there were specific interventions implemented			

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	on the purple colored wound assessment and tracking forms after the wounds developed. Finally, she indicated care plans were not implemented until day 21 of the resident's stay at the facility. 3. A clinical record was completed on 2/22/2016 at 11:00 A.M., for Resident #61 and indicated Resident #61 was admitted on 9/9/2015. The diagnoses included, but were not limited to: hypertension, diabetes mellitus and coronary artery disease. A review of Resident #61's ICARE (a care plan that is written in first person) did not indicate any skin risk interventions. A "SKIN IMPAIRMENT CIRCUMSTANCE ASSESSMENT AND INTERVENTION" form, dated 9/28/2015, indicated Resident #61 developed two stage two pressure ulcers. During an interview on 2/22/2016 at 12:37 P.M., the Corporate Nurse indicated that the facility does not provide CNA (Certified Nursing Assistant) careguides. She further indicated that the CNAs would find the information they needed from the ICARE plans.			

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	During an interview on 2/22/2016 at 12:50 P.M., CNA #2 indicated she would go to the facilities ICARE plans to find out how to provide care to residents. The facility policy and procedure, titled, "General Wound and Skin Care Guidelines", undated and provided on 02/22/16 at 3:30 P.M. by RN (Registered Nurse) #1, included the following: "...2. Turn/reposition residents who are immobile according to their care plan requirements...5. Evaluate the need for a pressure reduction surface for bed/chair and the need for the elbow protectors and/or heel floats...22. Educate residents/significant others on weight shifting in bed/chair and other interventions to prevent skin breakdown." The Interdisciplinary Team Care Plan Guideline policy, revised on 06/15 and provided by RN #1, the Nursing Consultant on 02/22/16 at 3:30 P.M., indicated an initial care plan was to be included on the Admission Nursing Assessment initiated within 24 hours and completed within 72 hours of admission to address pertinent areas of care, treatment and risk. A comprehensive care plan was to be completed within 7 days of the completion of the admission comprehensive MDS assessment.			

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	3.1-40(a)(1)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure appropriate interventions were in place to prevent a decline in incontinence status for 1 of 3 residents reviewed for incontinence. (Resident #29) Finding includes: On 02/18/2016 at 4:22 P.M. the clinical record for Resident #29 was reviewed. Resident #29 was admitted on 12/26/2015. The diagnoses included, but were not limited to: kidney failure, enlarged prostate without lower urinary tract symptoms, Parkinson's disease and dementia without behavioral disturbance.	F 0315	1. Resident #29 had a bladder re-assessment completed. Resident #29 has been placed on a toileting schedule that is tracked on Point of Care to ensure toileting schedule is being adhered to. 2. Current residents MDS's reviewed for change in bladder status. Other residents that have incontinence and are appropriate have been placed on toileting schedules that are tracked on Point of Care to ensure schedule is being adhered to. 3. MDS Coordinator has been re-inserviced to notify Director of Health Services/designee when a change in bladder status is noted to complete a bladder re-assessment. Licensed nurses have been re-inserviced	03/24/2016

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	An MDS (Minimum Data Set) assessment, dated 11/15/2015, indicated Resident #29 had a change in bladder status from occasionally incontinent to frequently incontinent. There was no documentation in the record to indicate a bladder assessment was completed following Resident #29's change in status. During an interview on 2/23/2016 at 1:38 P.M., the DON (Director of Nursing)indicated that she was unaware of why Resident #29 went from occasionally incontinent to frequently incontinent and there was not a bladder assessment completed following the status change. She further indicated that it was her practice to complete an assessment when a resident experiences a status change. During an interview on 2/23/2016 at 2:30 P.M., the MDS coordinator indicated that she did not notice a change in Resident #2 status because she wasn't here for the previous MDS. She indicated the staff did not notice a change and that when a change has been found on an MDS, the resident is medically evaluated and an assessment is completed to see why the resident has experienced a decline.		on bladder guidelines. 4. Director of Health Services/designee will audit 5 residents MDS per week to ensure any change in continence status is reflected and a bladder re-assessment will be completed on residents with change in bladder status. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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	A policy was provided by the corporate nurse on 2/23/2016 at 1:15 P.M., titled "Bowel and Bladder Continence" undated, and indicated this was the current policy used by the facility. The policy indicated "...PROCEDURE: Complete a bowel and bladder assessment as part of the admission nursing assessment and implement care plan interventions as appropriate...." 3.1-41(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on interview and record review the facility failed to provide Resident #29 with a functioning call light and alarm which resulted in a fall with fracture. This had the ability to affect 1 of 4 residents reviewed for accidents. (Resident #29) B. Based on observation and interview, the facility failed to provide a safe	F 0323	1. Resident #29 returned to the facility after treatment at the attending hospital. Resident call light is in working repair. All power strips were removed out of the resident's pathway. 2. All residents call lights were assessed and are in working repair. All residents that have tab monitors were assessed and are in place. All rooms were assessed for power strips to ensure they were not in the	03/24/2016

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	environment for residents related to power strips observed on the floor for 4 of 31 resident rooms that had power strips in their room. (Rooms 102,106,108 and 202) Findings include: A. 1. A clinical record review was completed for Resident #29 on 2/18/2016 at 4:22 P.M. The diagnoses, included but were not limited to: kidney failure, enlarged prostate without lower urinary tract symptoms, malaise, fatigue, major depressive disorder, Parkinson disease, dementia without behavioral disturbance, difficulty in walking and muscle weakness. A physician's order, dated 1/15/2016, indicated Resident #29 was to have a clip alarm when in wheelchair. A physician's order, dated 1/26/2016, indicated Resident #29 was to have a clip alarm on his bed and chair. An incident report provided by the corporate nurse on 2/22/2016 at 12:36 P.M., indicated Resident #29 was found on the floor next to the bed after attempting to transfer himself to bed, on 2/7/2016 at 8:45 A.M. The incident report further indicated that Resident #29		resident pathway for ambulation. 3. Nursing staff was re-inserviced on following the Care plan related to safety devices to prevent falls. Nursing staff was re-inserviced on proper notification of non functional equipment. Nursing staff was re-inserviced on monitoring for potential hazards in the residents walking pathways that may cause potential hazards. DPO will monitor 5 rooms per day/5 times per week for functional call light systems and powered strips are not in resident's pathway. Any deficiencies will be corrected immediately at that time. Nursing Admin or designee will monitor 5 residents per day/5 times per week to ensure safety devices are in place. This will include random audits on all 3 shifts. DPO and DHS or designee will report findings to QA&A for 6 months or until 100% compliance is obtained. 4. QA&A will monitor for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the plan of correction as needed.	

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	was sent to the hospital and underwent a surgery to repair a right femoral neck fracture. A witness statement, dated 2/7/2016, indicated there was no alarm on the resident or in his room. The witness statement indicated the resident had a "valid clip alarm while in chair" order. Employee #3 also indicated the call light was malfunctioning. She indicated she tried to plug it in correctly "20-40 minutes" prior to the incident but was unable to fix it. A witness statement by employee #4, dated 2/7/2016, indicated Resident #29's "...call light wasn't working properly and I did not know that (Employee #5) was the one that told me that the call light wasn't working right. (Employee #6) was here that should of been reported to her. She would of went to get a new one, which she did after we found out it was not working right...." A review of the current care plan was conducted on 2/22/2016 at 2:50 P.M., and indicated Resident #29 was care planned to have tab alarms in place while in bed and in chair. The care plan further indicated to keep his call light within easy reach to prevent him from overstretching.			

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	During an interview on 2/22/2016 at 12:16 P.M., the corporate nurse indicated Resident #29 did not have an alarm in place nor did he have a functioning call light in his room at the time of his fall.			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interviews, the facility failed to ensure there was adequate indications to support the use of an antipsychotic medication and adequate monitor of medical	F 0329	1. Resident #54 assessed and medication use is appropriate at present time, resident behaviors monitored daily. Resident #10 has had their antipsychotic/antianxiety medication reviewed based on	03/24/2016

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	symptoms for 1 of 5 residents reviewed for unnecessary medication use. (Resident #54) The facility failed to ensure there were adequate indications to support an increase in an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 10) Findings include: 1. The clinical record for Resident #54 was reviewed on 02/18/2016 at 2:06 P.M. Resident #54 was admitted to the facility, on 11/13/14, with diagnoses, including but not limited to: cellulitis, history of falls, right hip fracture, dementia and peripheral neuropathy. The current physician's orders for medications for Resident #54 included the following the antipsycotic medication, Seroquel 75 mg (milligrams) at bedtime for dementia with delusions. Documentation provided by RN (Registered Nurse) #1, the nursing consultant, on 02/19/16 at 2:45 P.M., indicated the Seroquel had been ordered for Resident #54 on 04/23/15. The initial physician's order indicated the resident was to receive 100 mg in the morning and 200 mg at bedtime. A psychiatric consult was ordered, an antibiotic to treat		daily observations of behaviors and request was made to psych services for GDR. 2. Current residents receiving antipsychotic/antianxiety medications have been reviewed to ensure adequate indications to support use of medications. Behavior programs have been developed for residents currently receiving antipsychotics/anxiolytics/hypnotics that indicates individualized behaviors and interventions that are tracked daily. 3. Nursing staff have been re-inserviced that any changes in behavior are to be reported to Social Service Director/Director of Health Services before medication requests are made to physician. Non-pharmalogical interventions are to implemented and documented before new/increased medications are started. 4. Director of Health Services/designee will audit 5 residents per week to ensure any change DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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	cellulitis, and a urinalysis and blood tests were ordered. A Mental Health Wellness Circumstance, Assessment and Investigation form, initiated on 04/23/15, indicated the resident had verbal issues, mood swings, was yelling out and refusing meals. The resident was documented as anxious, irritable, had a loss of interest, persistent anger and a change in mood. There was no information regarding the resident's behaviors and any non pharmalogical interventions provided prior to the 04/23/15 documentation, the day the antipsychotic medication Seroquel was initiated. It was not clear how long the resident had been exhibiting behavioral issues, how severe and frequent the behaviors had been, or if any non-pharmalogical interventions had been attempted. The 04/23/15 documentation did mark some interventions attempted for that particular day. In addition, the care plan for Resident #54, provided on 02/15/16, indicated a plan to address the resident's mood and behavior. The plan indicated the resident received antianxiety, antidepressant, and psychotropic medication for depression, anxiety, and Dementia with behavior			

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	disturbance. There was no documentation of what the "behavioral disturbance" was or any delusions and the only intervention was to administer medication, observe the resident for side effects, notify the medical doctor of any adverse side effects. There were no nonpharmalogical interventions to address the resident's delusional behavior. During an interview on 02/22/15 at 11:00 A.M., the SSD (Social Sevice Director) indicated she added updates to the care plan the last week for February and added Delusions. The updated care plan now had an interventions to redirect the resident to an activity if he has delusions of needing a ride to Milford or working on tractors. An interview was conducted on 02/22/2016 at 2:45 P.M., with CNA (Certified Nursing Assistant) #23 and #24 regarding behaviors they were to monitor for Resident #54. Both CNA's indicated sometimes towards the evening the resident became agitated. They indicated if the resident was agitated they would remove him from the situation and offer him a snack or drink. Both CNA's indicated the resident did not exhibit delusions but was often confused and thought the facility was the factory where			

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	he had worked. Neither CNA was aware of any new intervention for addressing the resident's delusional behavior or even how the resident displayed delusional behavior. 2. On 2/18/2016 at 9:51 A.M., a clinical record review was completed for Resident #10 and indicated the resident was admitted on 1/15/2013. Diagnoses include: Dementia with behavioral disturbance, dysphasia, weakness, urinary incontinence, urination urgency, hypothyroidism, gout, hypertension and esophageal reflux. A physician's order, dated 12/22/2015, indicated Resident #10 was ordered Seroquel (an antipsychotic medication) 12.5 mg (milligrams) every other day. A social service note, dated 1/8/2016, indicated Resident #10 was "...doing ok so far with the reduction...." On 2/18/2016 at 11:00 A.M., a "Behavior Detail Report" indicated Resident #10 had a "socially inappropriate behavior/other." The report showed no further events since the prior dosage reduction on 12/22/2015 thru 2/18/2016 when the documentation was reviewed. A physician's order, dated 1/18/2016,			

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	indicated Resident #10 was placed back on Seroquel 12.5 mg every day for worsening behaviors. During an interview on 2/18/2016 at 1:56 P.M., the social service director indicated Resident #10 had only one episode of behaviors and this did not indicate the use of an antipsychotic medication. On 3/18/2016 at 3:00 P.M., the Corporate Nurse provided a policy titled, "GUIDELINES FOR: Psychotropic Medication Usage and Gradual Dose Reductions" dated August 2013, and indicated this was the policy currently used by the facility. The policy indicated "...1. Resident shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnoses or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...." and "...9. Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of in addition to, medications...." 3.1-48(a)(6)			

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F 0334 SS=D Bldg. 00	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is			

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	medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure a resident was offered an influenza vaccine and failed to obtain a resident signature on an informed consent indicating a refusal of the influenza immunization. This deficient practice affected 2 of 5 residents who were reviewed for the influenza vaccine. (Resident #29 and Resident #42) Findings include: A facility form titled,"Influenza Immunization Education and Informed	F 0334	1. Resident #29 and #42 have signed influenza consents present in there chart. 2. All residents were reviewed for the presence of signed influenza consents. 3. Nursing staff was inserviced that the influenza vaccine is to be offered from October 1st to March 31st on all current and new residents. Consents must be signed by resident or responsible party/or verbal consent for acceptance or declination. 4. Monitoring will be completed by DHS or designee by auditing 5 residents weekly to ensure all residents have been	03/24/2016

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	Consent," dated 10/26/15, indicated Resident #42 refused the influenza vaccine. The form was not signed by the resident or a responsible party. During an interview, on 2/23/16 at 10:39 A.M., RN (Registered Nurse) #1 indicated a resident or their representative should always sign the consent even if they are refusing the vaccination. A facility form titled, "Influenza Immunization Education and Informed Consent", dated 8/18/15, indicated Resident #29 refused the influenza vaccine. Hand written on the reason line was: had. The form was signed by the resident's responsible party. During an interview, on 2/23/16 at 11:46 A.M., the Director of Nursing indicated when the resident is offered the influenza vaccine outside of the time frame for the influenza season, the vaccine should be reoffered between October 1st and March 31st. On 2/23/16 at 12:00 P.M., RN #1 provided a policy titled "Guidelines for Influenza and Pneumococcal Immunizations", dated August 2014, and indicated the policy was the one currently used by the facility. The policy indicated		offered the influenza vaccine until March 31, 2016. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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	"...2. Upon admission and annually each resident/responsible party will sign an informed consent form indicating the acceptance/refusal of immunization...." 3.1-13(a)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation the facility failed to follow proper food handling techniques in the kitchen. This had the ability to affect 51 of 52 residents who eat from the facility kitchen. Finding includes: During a kitchen observation on 02/15/2016 at 12:01 P.M., the following was observed: Employee #8 picked up a bread bag, sauerkraut can, and a bag of beef cold cuts while wearing gloves. She than proceeded to put her gloved hand into the	F 0371	1. The dietary staff members involved immediately re-washed their hands and donned new gloves until meal service was complete. Potentially contaminated resident trays were set aside and new trays were prepared for those residents. Staff members involved were promptly in-serviced on proper sanitary techniques for service on the tray line. 2. No residents were affected. 3. Dietary staff have been re-in-serviced by the Director of Food Services or designee on the Trilogy Guideline titled "Food Production Guidelines-Sanitation & Safety". 4. Director of Food Services/designee will audit 5	03/24/2016

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	bag of cold cuts and bread to make a sandwich. A soiled plate was observed sitting on the trash can. Employee #9 picked up the plate from the trash can and placed it on the counter she was serving from. Another employee picked up the plate and placed it back on the trash can. Employee #9 picked up the plate and placed it on the serving area again. She then continued to serve food to the residents. Employee #9 observed to receive a cup of soup from a CNA (Certified Nursing Assistant) that had already been served and used by a resident. Employee #9 sat the cup aside and continued serving residents without washing her hands. A policy provided by the Corporate Nurse on 2/23/2016 at 2:18 P.M., titled "Good Production Guidelines-Sanitation & Safety" dated 2009, and indicated this policy was the one currently used by the facility. The policy indicated "...1. Hands are washed thoroughly before touching food or equipment...." 3.1-21(i)(3)		meal services weekly to ensure sanitary guidelines are followed. DFS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	

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F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observations, record review and interviews, the facility failed to promptly refer 1 of 3 residents reviewed for dental needs with lost dentures to a dentist. (Resident #54) Finding includes: The clinical record for Resident #54 was reviewed on 02/18/2016 at 2:06 P.M. Resident #54 was admitted to the facility, on 11/13/14, with diagnoses, including but not limited to: cellultis, history of falls, right hip fracture, dementia, osteoarthritis, hypertension, glaucoma, insulin dependent diabetes mellitus, and peripheral neuropathy. The initial nursing assessment, completed on 11/13/15, indicated the resident had no natural teeth and no problems with his dentures or mouth. Upper and lower dentures were marked on his personal	F 0412	1. Resident #54 dentures were replaced. 2. All residents with dentures had the potential to be effected by this practice. 3. All facility staff will be re-inserviced on the trilogy guidelines titled "Service Recovery Process and Follow up" by the Director of Social Services/Designee. All residents assessed by licensed staff for presence of dentures. 4. Social Service Director or designee will audit 5 residents weekly to ensure dentures are present. DHS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	03/24/2016

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	inventory form. An interview was conducted with the representative for Resident #54 on 2/16/2016 at 02:36 P.M. The representative indicated Resident #54's bottom dentures were lost on December 24. The representative indicated they had complained to the staff regarding the lost dentures on Christmas morning but it took over a month to get anyone to do anything about the lost dentures. The representative indicated they were asked to complete a form and now the resident had been seen by a dentist and had impressions made so the lost dentures could be replaced. A Resident Concern Form, completed by family of Resident #54, dated 12/25/15, indicated the lower dentures had been missing since 12/25/15, and had last been seen by family on 12/24/15. The resident's son had visited, on 12/25/15, and was told "it was being taken care of." On top of the form was the date 01/23/16, circled with "turned in" handwritten by the circled date. During an interview on 02/22/2016 at 10:06 A.M., the SSD (Social Service Director) indicated between Christmas and January 23, 2016, staff had told her about missing dentures for Resident #54.			

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	She indicated staff had lost the dentures then found them, then lost them again. The SSD indicated Resident #54 had a history of taking his dentures out and putting them places. On 01/23/16, after speaking with Resident #54's family, she had looked and both the top and bottom dentures for Resident #54 were missing. The SSD indicated she had spoken with Resident #54's family the day before and they were aware staff were looking for his dentures. She indicated she did not document the times and dates staff had notified her of the missing dentures but she was not aware of the continued issue with the dentures until 01/22/16 when she had spoken with Resident #54's family. She also indicated nursing staff should have completed a concern form regarding the missing dentures. A dental exam, completed on 02/01/16, by the in house dentist indicated impressions were completed as the resident's lower dentures were not worn - patient stated they were lost and the upper dentures were older. 3.1-24(a)(3)			

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F 0456 SS=F Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed to maintain the kitchen dishwasher in a sanitary manner. This had the ability to affect 51 of 52 residents who eat from the kitchen. Finding includes: During a kitchen tour on 2/15/2016 at 10:16 A.M., the dishwasher was observed to reach a temperature of 170 degrees Fahrenheit. "Clean" dishes were removed from the dishwasher after the cycle and were observed to have particles of food on them. During an interview on 2/15/2016 at 10:30 A.M., Employee #10 indicated the rinse cycle should be reaching 180 degrees Fahrenheit and acknowledged the dishes were coming out of the dishwasher soiled. A record review of the "Daily Data Sheet" indicated the rinse cycle had been between 170-171 degrees Fahrenheit from 2/7/2016 to 2/14/2015.	F 0456	1. The dishwasher was repaired to have rinsing cycle temperature between the proper parameters. All dishes were sent back through the dishwasher to ensure proper sanitation. 2. No residents were affected. 3. Dietary staff have been re-inserviced by the Director of Food Services or designee on the manufactures guideline for the dishwasher that indicates the rinse cycles should be 180-195 degrees Fahrenheit. Temperatures will be continued to be monitored daily at all three meals. 4. Monitoring will be completed by The Director of Food Services or Designee by observing 3 dishwashing cycles daily prior to dishes going through to ensure rinsing is being completed at the proper temperature. DFS/designee will report findings to QA&A for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations as needed.	03/24/2016

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	A review of the manufactures guidelines for the dishwasher was conducted on 2/15/2016 at 11:30 A.M., and indicated the rinse cycle should be between 180 - 195 degrees Fahrenheit. 3.1-19(f)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 provide the resident environment in good repair related to scrapes and gouges in doors and walls in resident rooms and bathrooms. This had the potential to affect 4 of 19 residents residing on the East hallway, and 4 of 27 residents residing on the South hallway. Findings include: On 2/22/16 from 9:15 A.M. to 9:50 A.M., an environmental tour was conducted of the facility with the Administrator, the Maintenance Director, the Environmental Services Director and the Housekeeping Supervisor, during which the following was observed:	F 0465	1. Room 101B bi-fold doors have been fixed. Room 106B bi-fold doors were fixed. Room 203 scrapes were fixed. Room 207 restroom scrape in the wood was fixed. 2. All rooms were review for any areas of scrapes/gauges. All deficiencies noted were corrected at that time. 3. DPO has been re-inserviced on ensuring the rooms are in good repair. DPO or designee will monitor 5 rooms per week to ensure the rooms are good repair. DPO will report his findings to QA&A monthly for 6 months. 4. QA&A will monitor monthly for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and recommendations to the Plan of Correction as needed.	03/24/2016

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	1. East Hallway: At 9:15 A.M., Room 101 bed B the bi-fold closet doors was observed to have scrapes and gouges on the sides of the doors. The scrapes were deep enough it exposed the bare wood underneath the paint. At 9:20 A.M., Room 106 bed B the bi-fold closet doors was observed to have gouges in the paint exposing the bare wood underneath the paint. 2. South Hallway: At 9:45 A.M., the shared restroom for Room 203 was observed to have a large scrape approximately 6 inches in width and 3 inches in length exposing the drywall underneath the paint on the wall across from the toilet. At 9:50 A.M., Room 207 bed A the restroom door was observed to have a scrape in the wood approximately 4 inches from the bottom of the door. During an interview on 2/22/16 at 9:55 A.M., the Maintenance Director indicated the doorways, walls and closets are always getting scraped with wheelchairs and it is hard to keep up on the repairs.			

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	3.1-19(f)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee staring work. (1) At the time of employment, or within (1) month prior to employment, and a least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during	F 9999	3.1-14 1. Employee #31 has been given the 1st step and 2nd step mantouxs. 2. Employee files have been audited and any other deficiencies noted were corrected at that time. 3. AP/Payroll will monitor all new hires to ensure the mantoux are being completed in regulation time frames. AP/Payroll will monitor all new hires for the completion of 1st and 2nd step mantoux. AP/Payroll will report findings to QA&A monthly. 4. QA&A will monitor monthly for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to the plan of corrections as needed. 3.1-1 1. Employee #33, #34, have completed their 3 hours of Dementia training. 2. Employees files were reviewed to ensure 3 hour of Dementia training was completed. Any deficiencies noted at that time were corrected. 3. Nsg Administration was re-inserviced on Dementia requirement training. NSG Admin will monitor for 5 employee records per week to ensure dementia training completions. DHS or designee	03/24/2016

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	155495	A. BUILDING 00 B. WING	02/23/2016

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LAKELAND REHABILITATION AND HEALTHCARE CENTER	505 W 4TH ST MILFORD, IN 46542

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	the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 10 employees had a first step Mantoux skin test read with 48-72 hours of administration. (Employee #31) Finding includes: A review of personnel files was conducted on 2/23/16 at 10:00 A.M. and indicated the following: Employee #31, a certified nursing assistant, had a start date of 2/2/16. A form titled "Tuberculin Testing for Employees," dated 1/28/16, indicated Employee #31 was administered a 1st step Mantoux (a test to screen for Tuberculosis) on 1/28/16. The date read section was blank. The form indicated "...This test must be read 48-72 hours		will report findings to monthly to QA&A. 4. QA&A will monitor monthly for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of correction as needed. 1. Employee #33 was in serviced on resident's rights. 2. Employee personal files were reviewed to ensure employees have received resident rights in-services. 3. Nsg Administration has been re-inserviced on the residents rights required in-services. AP/Payroll will monitor all new associates to ensue they have completed the residents rights inserviced. AP/Payroll will report findings to QA&A monthly. 4. QA&A will monitor monthly for 6 months or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to the plan of correction as needed.	

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	after the injection. Bring this form with you to a nurse on duty that is authorized to read the test. If the test is not read on time, it will have to be repeated...." During an interview on 2/23/16 at 11:25 A.M., Employee #32 indicated she was aware the 1st step Mantoux was not read timely and the Mantoux testing was started over for Employee #31. On 2/23/16 at 1:10 P.M., RN (Registered Nurse) #1 provided a policy titled "Guidelines for TB [Tuberculin] Results Summary Documentation: Staff", dated 3/24/2008, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis. 2. The results of the baseline PPD test, the Mantoux test shall be recorded in the TB Results Summary and placed in the personnel file...." 3.1-14(t) 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6)			

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	months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs of preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the required dementia inservicing was completed for 2 employees in a sample of 10. (Employee #33 and #34) Finding includes: A review of personnel files was conducted on 2/23/16 at 10:00 A.M. and indicated following: 1. Employee #33's file showed no documentation of the 3 hour annual dementia training. 2. Employee #34's file showed no documentation of the 3 hour annual dementia training. During an interview on 2/23/16 at 11:25			

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	A.M., Employee # 32 indicated she just became aware that Employee #33 and #34 had not completed their annual dementia training. On 2/23/16 at 1:10 P.M., RN #1 provided a policy titled "Dementia Training", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...All nursing home staff with regular resident contact must receive six hours of dementia specific training within six months of hire. Three hours of dementia specific training required annually thereafter...." 3.1-14(u) 3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Resident's rights. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the required resident rights inservicing was completed for 1 employee in a sample of 10.			

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	(Employee #33) Finding includes: A review of personnel files was conducted on 2/23/16 at 10:00 A.M. and indicated the following: Employee #33's file showed no documentation of resident rights training. During an interview on 2/23/16 at 11:25 A.M., Employee # 32 indicated she was aware that Employee #33 did not complete the resident rights inservice. 3.1-14(k)(1)			