STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 7, 8, 12, 13, 14 and 15, 2019. Facility number: 011296 Provider number: 155763 AIM number: 19112962 Census Bed Type: SNF/NF: 40 Residential: 12 Total: 52 Census Payor Type: Medicaid: 29 Other: 23 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 19, 2019.	F 0000	This plan of correction is to serve as North Ridge Village Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.	
F 0582 SS=A Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;			

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

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	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the			

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	resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview the facility failed to ensure 2 of 3 residents reviewed received written notification prior to skilled services being completed. (Resident 18 and Resident 36) Findings include: On 11/14/19 at 1:25 P.M., the Beneficiary Notice-Residents Discharged Within the Last Six Months form was reviewed and indicated Resident's 18 and 36 had received Skilled Nursing Services. The SNF (Skilled Nursing Facility) Beneficiary Protection notification Review form indicated the following: Resident 18 had received Medicare Part A Skilled Services on 5/18/19 to 6/21/19. There was no documentation a SNF ABN (Advance Beneficiary Notice of Non-Coverage) and a NOMNC (Notice of Medicare Non-Coverage) was or was not provided to the resident. The SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form indicated the following: Resident 36 had received Medicare Part A Skilled Services on 8/14/19 to 10/11/19. There was no documentation a SNF ABN (Advance Beneficiary Notice of Non-Coverage) and a NOMNC (Notice of Medicare Non-Coverage) was or was not provided to the resident. On 11/14/19 at 1:47 P.M., an interview was conducted the Minimum Data Set (MDS)	F 0582	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 16 and 36 will not have any adverse effects related to this alleged deficient practice. Residents 16 and 36 will be issued an ABN and NOMNC 48 hours in advance prior to a skilled level of care ending. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. All residents on a skilled level of care stay will be issued an ABN and NOMNC 48 hours in advance prior to their skilled level of care ending. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** MDS Coordinator will be responsible for issuing all ABN's and NOMNC's with BOM/HR Director as back up person. MDS	12/15/2019

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	assessment Consultant indicated there were no SNF Beneficiary Protection Notification for Resident 18 and Resident 36. On 11/14/19 at 2:42 P.M., an interview with Human Resources indicated she could not find any documentation that Resident 18 and Resident 36 had been given a 2 day notice prior to their skilled services ending. On 11/14/19 at 2:44 P.M., an interview was conduct with the Health Facility Administrator and requested the policy for SNF Beneficiary Protection Notification which was not provided. 3.1-4(f)(1)(2)		Coordinator and BOM/HR Director will be in-serviced 12-4-19 regarding policy and procedures relating ABN's and NOMNC's. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Administrator and/or Designee will monitor all ABN's and NOMNC's monthly for 6 months, then quarterly thereafter. Any negative findings will be corrected immediately and forwarded to the Regional MDS Consultant. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment I).	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			

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	§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and			

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	submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate			

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	relocation of the residents, as required at § 483.70(l). Based on record review and interview the facility failed to ensure the resident's representative was provided a written transfer notice when the resident was transferred to the hospital for 1 of 1 residents reviewed .(Resident 23) Findings include: On 11/12/19 at 10:33 A.M., the Clinical Record of Resident 23 was reviewed. Diagnosis included, but were not limited to, pulmonary fibrosis and pneumonia. The SBAR (is an acronym for Situation, Background, Assessment, Recommendation) Communication Form dated 8/21/19 indicated the following: the resident had signs of abdominal distention and was non-responsive. Resident 23's Physician had been notified and the resident was transferred to the hospital emergency room. There was no documentation the resident or resident's representative had been notified of his transfer in writing and provided the appeal rights information in writing when the resident was sent out to the hospital. The most current undated policy titled North Ridge Village Nursing and Rehab Bed Hold/Readmission Policy was received from Medical Records on 11/14/19 at 10:30 A.M. The policy indicated, but is not limited to the following: "On admission to the facility, the Community Liaison Director will explain the policy to the resident, family or representative and provide them with at (sic) (a) copy of the packet to keep with their records. An acknowledgement of	F 0623	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 23 will not have any adverse effects related to this alleged deficient practice. Resident 23 and POA will be notified in writing within 24 hours of the resident's transfer/discharge. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. All residents and their POA will be notified in writing within 24 hours of the resident's transfer/discharge. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All residents and their POA's will be notified in writing within 24 hours of the resident's transfer/discharge. All nursing staff will be in-serviced 12-4-19 regarding policy and procedures relating transfer/discharge of residents.	12/15/2019

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	receipt will be signed at that time to be kept on the resident's chart. The bed hold packet shall include: a copy of the policy, notice of transfer or discharge and transfer or discharge request for hearing.... In cases of emergency transfer, a notice 'at the time of transfer' means that the family, surrogate or representative is provided with written notification within 24 hours of the transfer. This requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital." On 11/14/19 at 10:46 A.M., an interview, conducted with Medical Records, indicated she had reviewed Resident 23's record and was unable to find documentation a Notice Of Transfer Or Discharge form had been provided to the resident's representative. On 11/14/19 at 10:50 A.M., an interview, conducted with Licensed Practical Nurse (LPN) 2, indicated the nurse who had documented the resident's condition should have provided Resident 23's representative with a written Notice Of Transfer Or Discharge form. On 11/14/19 at 10:58 A.M., an interview was conducted with Health Facility Administration indicated the nurse who had sent the resident to the hospital emergency room should had provided the resident's representative in writing a Notice Of Transfer Or Discharge form. 3.1-12(a)(6)(A)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** D.O.N and/or Designee will monitor all transfer/discharges weekly for 8 weeks, then monthly for 4 months, then quarterly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment J).	
F 0625 SS=A Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return-			

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	§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review the facility failed to ensure a written bed hold policy was provided when the resident had been transferred to the hospital for 1 of 1 residents reviewed . (Resident 23) Findings include: On 11/12/19 at 10:33 A.M., the Clinical Record of Resident 23 was reviewed and indicated diagnosis	F 0625	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 23 will not have any adverse effects related to this alleged deficient practice. Resident 23 and/or POA will be notified of the facilities bed hold policy upon the resident's transfer/discharge.	12/15/2019

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	included, but were not limited to, pulmonary fibrosis and pneumonia. The SBAR (is an acronym for Situation, Background, Assessment, Recommendation) Communication Form dated 8/21/19 indicated the following: the resident had signs of abdominal distention and was non-responsive. Resident 23's Physician had been notified and the resident was transferred to the hospital emergency room. There was no documentation that a bed hold policy had been provided when the resident had been sent to the hospital. The most current undated policy titled North Ridge Village Nursing and Rehab Bed Hold/Readmission Policy was received from Medical Records on 11/14/19 at 10:30 A.M. The policy indicated, but is not limited to, the following: "POLICY: Before transferring a resident to a hospital ...the facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed hold policy during which the resident is permitted to return and resume residence in the facility. In cases of emergency transfer, the family, surrogate, or representative will be provided with written notification within 24 hours. PROCEDURE: On admission to the facility, the Community Liaison Director will explain the policy to the resident, family or representative and provide them with at (sic) (a) copy of the packet to keep with their records. An acknowledgement of receipt will be signed at that time to be kept on the resident's chart. The bed hold packet shall include: a copy of the policy...In cases of emergency transfer, a notice 'at the time of transfer' means that the family, surrogate or representative is provided with written		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. All residents and/or POA will be notified of the facilities bed hold policy upon the resident's transfer/discharge. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All residents and/or POA will be notified of the facilities bed hold policy upon the resident's transfer/discharge. All nursing staff will be in-serviced 12-4-19 regarding policy and procedures relating to the facilities bed hold policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** D.O.N and/or Designee will monitor all transfer/discharges weekly for 8 weeks, then monthly for 4 months, then quarterly thereafter to ensure the facilities bed hold policy was provided. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress	

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	notification within 24 hours of the transfer. This requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital." On 11/14/19 at 10:46 A.M., an interview, conducted with Medical Records, indicated she had reviewed Resident 23's record and was unable to find documentation a bed hold policy had been provided to the resident's representative. On 11/14/19 at 10:50 A.M., an interview, conducted Licensed Practical Nurse (LPN) 2, indicated the nurse who had documented the resident's condition should had provided Resident 23's representative with a bed hold policy. On 11/14/19 at 10:58 A.M., an interview, conducted with Health Facility Administration, indicated the nurse who had sent the resident to the hospital should had provided a bed hold policy to the resident's representative. 3.1-12(a)(25)(26)		will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment J).	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review the facility failed to ensure a Physician's order was followed for1 of 6 residents reviewed (Resident 25). Findings include:	F 0658	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 25 will not have any	12/15/2019

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	The clinical record for Resident 25 was reviewed on 11/7/19 at 11:23 A.M. Diagnoses included, but were not limited to, dementia, heartburn, and type 2 diabetes. A Physician's order dated 8/12/19, indicated Resident 25 was to receive 40 milligrams of Protonix daily. There was no documentation to indicate Resident 25 had received 40 milligrams of Protonix daily after the medicaiton was ordered on 8/12/19. The Director of Nursing Services DNS was interviewed on 11/14/19 at 1:48 P.M. During the interview the DNS indicated Resident 25 should have been receiving 40 milligrams of Protonix after being ordered on 8/12/19 and he had not been receiving the medication. 3.1-35(g)(1)		adverse effects related to this alleged deficient practice. Resident 25 is receiving Protonix 40mg daily. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. An audit will be completed on physician orders for the past 30 days. Any negative findings will result in MD and POA notification and documentation will occur in the resident's clinical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All physician orders will be addressed timely. All nursing staff will be in-serviced 12-4-19 regarding policy and procedures relating to physician orders and medication administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON and/or Designee will monitor all new physician orders daily on scheduled work days for 8 weeks, then weekly for 4 weeks, then	

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monthly for 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment D).	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview the facility failed to ensure wound care treatments were consistently documented for 1 of 2 residents reviewed. (Resident 20) Findings include: The Clinical Record of Resident 20 was reviewed on 11/13/19 at 2:28 P.M. The resident record indicated diagnoses included, but were not limited to, quadriplegia (paralysis of all 4 limbs), abnormal posture and chronic pain.	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 will not be affected by this alleged deficient practice. Resident 20 will have wound care treatments documented upon completion. **How other residents having the potential to be affected by the**	12/15/2019

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	The quarterly Minimum Data Set (MDS) assessment dated 9/3/19, indicated the resident was interviewable, and required extensive assistance of 1 person for bed mobility and transfers. The Nurses Note dated 11/11/19 at 10:15 P.M., indicated the resident was admitted to the hospital. The physician's order indicated the following: Dated 5/22/19 the resident had an air mattress on his bed, offload the resident's heels while in bed, received vitamin C 500 milligrams (mg) 2 times a day and received a daily vitamin 1 time a day. Dated 6/18/19, wash the resident's ischial wounds with soap and water, pat dry, insert gauze moistened with dakins and cover with an abdominal dressing. Change the dressing 2 times a day and follow up with the wound center in 3 weeks. Dated 10/15/19 give Remeron 7.5 mg 1 time a day as an appetite stimulant. Dated 11/6/19 give ProMod (liquid protein supplement) 30 milliliters (ml) 1 time a day for wound healing. Dated 11/9/19 give ProMod 60 ml 1 time a day. The October 2019 Treatment Administration Record (TAR) indicated the following: An order to wash Resident 20's ischial wounds with soap and water, pat dry, insert gauze moistened with dakins and cover with a dry dressing. Complete wound care on the day and the evening shift. The resident's treatment was not signed as done on the following dates: On 10/15, 10/17 and 10/28 on the evening shift. On 10/27 and 10/28 on the day shift.		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. An audit will be conducted on treatment documentation for the past 30 days. Appropriate staff will be notified of any missed documentation and corrective action will occur. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Documentation of wound care treatments will occur upon completion of treatment. All nursing staff to in-serviced 12-4-19 regarding policy and procedures relating to completion and documentation of wound care treatments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON and/or Designee will monitor treatment administration records for timely completion daily on scheduled work days for 8 weeks, then weekly for 8 weeks, then monthly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress	

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	There was no documentation the resident had refused the treatment to his wound. The Initial Pressure Ulcer Assessment form indicated the following: Resident 20 had a facility acquired stage 4 pressure ulcer to his right buttocks (ischial) that developed on 9/27/19. The wound was measured weekly on the following dates: On 10/10/19 the length was 4.5 centimeters (cm) by 3 cm in width and 1.8 cm in depth without tunneling or undermining. On 10/17/19 the length was 4.5 cm by 4 cm in width and 1.5 cm in depth without tunneling or undermining. On 10/23/19 the length was 4.5 cm by 4 cm in width and 0.1 cm in depth without tunneling or undermining. On 10/31/19 the length was 5 cm by 2 cm in width and 1.8 cm in depth there was tunneling or undermining at 12:00 of 1.0 cm with an illegible word with the letter "er" with a x marked through the "er" followed by the letters "ror". On 11/6/19 the length was 5 cm by 2 cm in width and 1.8 in depth with tunneling or undermining at 12:00 at 1 cm. On 11/13/19 there were no measurements because the resident remained in the hospital. The Physician's Orders dated 10/29/19 at 2:30 P.M., indicated Resident 20 had been seen by the Wound Center and the right ischium measured 5 cm in length by 2 cm in width and 1.8 cm in depth without tunneling or undermining. The care plan for the potential for impaired skin integrity related to Resident 20's immobility and quadriplegia date initiated on 8/27/13 indicated the resident had open area to his left and right buttocks. "...Wishes to spend most of the time up		will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment E).	

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	in chair, to smoke and is aware of (potential for) harm to self with infection and areas worsening. Date initiated: 8/27/13" Interventions included but, were not limited to, the following: "The resident needs assistance to turn/reposition at least every 2 hours as needed or requested. (Resident 20's name) refuses to reposition after he is up in his W/C (wheelchair). He remains in his w/c greater than 12 hrs most days despite continued education with discussion of risks vs. benefits of his choice. Date initiated: 8/27/13. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Date initiated 8/27/13...If the resident refuses treatment, confer with the resident , IDT (Interdisciplinary Team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Date initiated: 8/27/13...Roho cushion in w/c. Check inflation every shift. Date initiated 8/14/15. Transfer bar for bed mobility. Date initiated: 1/20/14." On 11/14/19 at 2:40 P.M., during an interview the Director of Nursing (DNS) indicated Resident 20 was extremely noncompliant with his treatments and sat in his wc for long periods of time. The DNS indicated the wound measurement of the resident's right buttocks, dated 10/23/19 was incorrectly documented 0.1 cm in depth because the week prior the depth was documented 1.5 cm and the week after 10/23/19 the depth was documented as 1.8 cm. On 11/15/19 at 8:57 A.M., during an interview, Certified Nursing Assistant (CNA) 2 indicated the resident refuses to lay down and wants up in his			

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	wc, and is non compliant with care. On 11/15/19 at 9:14 A.M., during an interview, CNA 1 indicated Resident 20 had refused showers at times and refused to allow staff to turn the resident because he likes to lay on back. The resident had a wc cushion and an air mattress on his bed and wore a boot when in bed. On 11/15/19 at 9:23 A.M., during an interview, CNA 3 indicated the following: The resident required extensive assist of a hoyer lift for transfers. Resident 20 lays on his back because when he laid on his side it was uncomfortable. The resident is usually in bed by 9:30 P.M. and had a sheep skin for back when he is sitting up in his wc. On 11/15/19 at 11:11 A.M., during an interview Licensed Practical Nurse (LPN) 2 indicated the resident had refused his treatment at times and was educated on being noncompliant with care and treatments. On 11/15/19 at 1:14 P.M., during an interview LPN 4 indicated Resident 20's wound had not been debrided by the wound clinic and thought the discrepancy in the wound measurements were because 2 different nurses had measured the resident's wound. On 11/7/19 at 11:30 A.M., Resident 20 was interviewed and indicated his treatments were done as ordered and that he had 7 pressure ulcers and now only had 2 pressure ulcers. On 11/7/19 at 11:30 A.M., the resident was observed sitting up in a wheel chair on a pressure reducing cushion.			

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	3.1-40			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications (Resident 31), received medications as ordered by a physician, and had adequate indications for a dosage increase of an antipsychotic medication. Findings include: Resident 31's clinical record was reviewed on 11/14/19 at 9:23 AM and indicated he was admitted to the facility with diagnoses including, but not limited to: moderate intellectual disabilities, dementia with behavior disturbances and psychotic disorder with delusions. On 3/27/18, a physician's order was received to start Resident 31 on Seroquel (an antipsychotic medication). On 10/10/19 a physician's order was received to decrease Seroquel from 25 mg (milligrams) at bedtime to 12.5 mg at bedtime. Resident 31's MAR (medication administration record) indicated on 10/10/19, 10/11/19, 10/12/19, 10/13/19 and 10/14/19, no Seroquel was given. On 10/15/19, a physician's order was received to increase Resident 31's Seroquel from 12.5 mg at	F 0758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 31 will not have any adverse effects related to this alleged deficient practice. Resident 31 recently returned from a hospital stay with Seroquel 50mg ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. An audit will be conducted on all GDR's for the past 6 months. Any negative findings will result in the resident's MD and POA being notified and documentation will occur in the resident's clinical record.	12/15/2019

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	bedtime to 25 mg at bedtime. On 10/28/19, a physician's order was received to increase Resident 31's Seroquel from 25 mg at bedtime to 50 mg at bedtime. A progress note dated 10/11/19, written by the SSD (Social Service Director) indicated Resident 31's family member was informed a GDR (gradual dose reduction) for Seroquel had occurred, and the dosage would be 12.5 mg. A nursing progress note from 10/15/19, at 2:47 PM indicated: "No adverse effects noted due to decreasing Seroquel. No change in mood or daily activities." A nursing progress note from 10/16/19 at 2:21 PM indicted: "No adverse effects noted to decreasing Seroquel. Resident's brother here to visit this shift and resident noted smiling and cooperative with care". A nurse progress note from 10/17/19 at 4:59 PM indicated: "No adverse reactions noted to decrease in Seroquel. Will continue to monitor". A nurse progress note from 10/20/19 at 12:58 PM indicated: "This writer is voicing concern of resident's general demeanor. Is becoming combative with care and when blood sugar is to be taken. Is not eating much at meal times-less than 40%. Does tell writer this AM that 'it hurts'." A nurse progress note fro 10/21/19 at 10:36 AM indicated: "Resident refused lab draws x 3 this morning. Swatting hands at writer and yelling 'No!' at lab tech while explaining procedures." A nurse progress note from 10/23/19 at 3:25 AM indicated: "...No behaviors or adverse reactions		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** GDR's will be completed timely on all residents receiving Psychotropic Drugs, unless previously contraindicated by the resident's physician. Appropriate behavior documentation will occur on all resident's receiving Psychotropic Drugs. All staff will be in-serviced on 12-4-19 regarding policy and procedures relating to the Behavior Management Program. In addition, all nursing staff will be in-serviced on 12-4-19 regarding policy and procedures relating to GDR's and documentation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** SSD and/or Designee will monitor dosage and behaviors daily on scheduled work days for all residents currently attempting a GDR on psychotropic drugs for 4 weeks, then weekly times 4 weeks, then monthly on-going. Any negative findings will be immediately corrected and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee for 6 months and plan adjusted accordingly.	

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	noted due to dosage reduction of Seroquel this shift." No other progress notes regarding Seroquel use were noted before the increase on 10/28/19 from 25 mg at bedtime to 50 mg at bedtime. On 11/14/19, at 11:04 AM, an interview was conducted with the SSD. The SSD indicated she had no documentation to show why Resident 31's Seroquel was increased from 12.5 mg to 25 mg on 10/15/19. The SSD indicated she did not know Resident 31's was again increased on 10/28/19 from 25 mg at bedtime to 50 mg at bedtime. The SSD indicated behavior tracking is done on nursing progress notes and CNA (Certified Nursing Aides) behavior management records. The SSD provided behavior management records for Resident 31 dated October 2019 which indicated two behavior episodes for the month: On 10/18/19, Resident 31 refused labs/swatting at staff and the approach used was explained procedure to the resident and was noted to be effective; 10/21/19, Resident 31 refused to give fingers for blood sugar and the approach used was conduct a medication review with the MD/Psych doctor and was noted to be effective. On 11/14/19, at 1:16 PM, an interview was conducted with Regional Director of Operations who indicated the facility had no documentation to show Resident 31 received any dosage of Seroquel from 10/9/19 through 10/15/19. The Regional Director of Operations provided a document which was not part of Resident 31's record, dated 10/25/19, titled 24 hour/change of condition report for multiple residents, which indicated Resident 31 had increased behaviors. The Director of Operations did not have any other documentation indicating Resident 31 was having			

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	behavioral problems between 10/10/19 and 10/28/19. The Regional Director of Operations provided a policy titled Antipsychotic Medication Use, revised 2/2013. Under Policy Interpretation and Implementation, 6. "The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. 7. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. " 3.1-48(b)(2)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review the facility failed to ensure laboratory tests were obtained as ordered for 1 of 6 residents reviewed (Resident 15). Findings include: The clinical record for Resident 15 was reviewed on 11/13/19 at 2:28 P.M. Diagnoses included, but were not limited to, anemia, dementia, heart disease, and fatigue.	F 0770	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 15 will not have any adverse effects related to this alleged deficient practice. MD and POA will be notified and BMP will be obtained. **How other residents having the**	12/15/2019

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	A Physician's order dated 2/9/19, indicated Resident 15 was to have a complete blood count (CBC) laboratory test every 6 months in January and July. There was no documentation indicating a CBC laboratory test had been completed in July, 2019. The Regional Director of Operations (RDOO) was interviewed on 11/15/19 at 12:43 P.M. During the interview the RDOO indicated Resident 15 should have had a CBC laboratory test in July, 2019 and she had not had one. A Physician's order dated 10/2/19, indicated Resident 15 was to have a CBC and basic metabolic panel (BMP) on 10/4/19. A laboratory report provided by the Regional Director of Operations (RDOO) on 11/15/19 at 2:46 P.M., indicated Resident 15 had a CBC on 10/4/19. The report also indicated the phlebotomist was unable to obtain the BMP on 10/4/19 and a second phlebotomist would be sent to collect the lab. There was no documentation indicating a BMP had been collected after 10/4/19. The RDOO was interviewed on 11/15/19 at 12:43 P.M. During the interview the RDOO indicated the BMP ordered for 10/4/19 had not been obtained and that the facility should have followed up with laboratory services. A policy, dated 6/2015, was provided by the RDOO on 11/15/19 at 2:14 P.M., titled "Laboratory Management" and she indicated it was the policy currently used by the facility. The policy indicated "Residents requiring laboratory services will		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. An audit will be conducted on labs for the past 6 months. MD and POA will be notified of any negative findings and lab will be obtained. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All lab orders will be obtained in a timely manner. All nursing staff to be in-serviced 12-4-19 regarding policy and procedures related to laboratory management. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON and/or Designee will monitor existing lab orders and new lab orders weekly for 8 weeks, then monthly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly (See Attachment G).	

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	receive accurate and timely laboratory services so that the utilization of laboratory testing for diagnosis, treatment, prevention, or assessment is maximized. The facility is responsible for quality and timely laboratory services whether or not services are provided by the facility or an outside agency." 3.1-49(a)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 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 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			

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's 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 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's 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 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. Based on interview and record review, the facility failed to ensure 1 of 5 residents (Resident 25) reviewed, were offered appropriate pneumococcal immunizations in a timely manner. Findings include: 1. Resident 25's clinical record was reviewed on 11/15/19 at 12:10 PM and indicated Resident 25 had received a dose of Pneumovax 13 prior to admission on 7/8/16. Upon admission to the	F 0883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 25 will not have any adverse effects related to this alleged deficient practice. Resident 25 will receive a pneumococcal vaccine per the most recent CDC guidelines, if consent is given. Resident and/or	12/15/2019

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	facility on 9/25/17, Resident 25 signed an acceptance for a pneumococcal immunization. Resident 25 did not receive a pneumococcal immunization after admission to the facility. On 11/15/19 at 1:40 PM, an undated policy was received from the Administrator titled "Pneumococcal Vaccine". The policy indicated "Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. CDC recommends a single dose of the pneumococcal vaccine for persons 65 years of age and older who have not been previously vaccinated or whose vaccination status is unknown. A onetime revaccination is recommended for persons 65 years and older who were vaccinated for the first time when they were 60 years of age or younger and it has been 5 or more years since the 1st dose. An interview with the Director of Operations on 11/15/19 at 2:45 PM indicated the policy provided was the most current one they could locate and indicated Resident 25 should have received the pneumococcal vaccines according to the CDC recommendations. 3.1-13(a)		POA will be provided with education related to the vaccine and an up-dated consent/declination will be signed prior to administration. Documentation will occur in the resident's clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. An audit will be conducted on all residents relating to the pneumococcal vaccine. Any negative findings will result in administration of the pneumococcal vaccine, education provided to POA and/or resident, and an up-dated consent/declination will e signed prior to administration of the vaccine. Documentation will occur in the resident's clinical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All new admissions will sign a consent/declination for administration of the pneumococcal vaccination. If consent to receive the vaccine is given, then the POA and/or resident will be provided educated	

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			related to the vaccine and the resident will be administered the vaccine in a timely manner and documentation will occur in the resident's clinical record. All nursing staff will be in-serviced on 12-4-19 regarding the policy and procedures relating to the pneumococcal vaccination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON and/or Designee will audit new admissions the day after admitting on scheduled work days ensuring pneumococcal vaccinations are administered in a timely manner once consent/declination is received. This audit will be conducted on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly if needed (See Attachment H).	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 7, 8, 12, 13, 14 and 15, 2019.	R 0000	This plan of correction is to serve as North Ridge Village Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by North	

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	Facility number: 012931 Residential Census: 12 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 19, 2019.		Ridge Village Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	Based on interview and record review, the facility failed to ensure staff certified in first aid were on site consistently. This had the potential to affect 12 of 12 residents residing in the facility. Findings include: On 11/15/19 at 12:45 PM, the Administrator provided the completed form titled "Residential CPR (cardiopulmonary resuscitation)/First Aid-Work Tool" dated 11/6/19 to 11/12/19. The Residential CPR/First Aide Work Tool indicated a first aid certified staff member was not on site during the following shifts: first shift on 11/9/19 and 11/10/19, second shift on 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, and 11/12, 2019, and third shift on 11/6/19 and 11/10/19. The Human Resource Director was interviewed on 11/15/19 at 12:15 P.M. During the interview the Human Resource Director indicated she thought nurses who had CPR also had first aid training. She also indicated there had been multiple shifts from 11/6/19 to 11/12/19 when a first aid certified staff member was not on site at the facility. The policy for assisted living staff qualifications was requested on 11/15/19 at 1:50 PM. The policy titled "First Aid Treatment," revised April 2010, did not address first aid certification requirements for assisted living staff.	R 0117	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident residing in the residential wing will be affected by this alleged deficient practice. Staff assigned to the residential wing will be CPR and First Aide Certified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents residing in the residential wing have the potential to be affected by this alleged deficient practice. No resident residing in the residential wing will be affected by this alleged deficient practice. Audit will be completed on all nursing staff related to CPR and First Aide Certifications. Staff assigned to the residential wing will be CPR and First Aide Certified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff and HR Director will be in-serviced on 12-4-19 related to CPR and First Aide Certifications. HR Director will monitor new hires for CPR and	12/15/2019

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			First Aide Certifications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** HR Director and/or Designee will monitor nursing staff and new hires for the nursing department for CPR and First Aide Certifications monthly on-going. DON and/or Designee will monitor daily on scheduled work days that staff assigned to the residential wing are CPR and First Aide Certified for 60 days, then weekly times 4 weeks, then monthly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly if needed (See Attachment A and B).	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the			

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	first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review the facility failed to ensure residents were receiving tuberculosis screening upon admission for 4 of 4 residents reviewed (Resident 1, Resident 2, Resident 5, and Resident 8). Findings include: 1. The clinical record for Resident 1 was reviewed on 11/15/19. Diagnoses included, but were not limited to, hypertension, type 2 diabetes and muscle weakness. There was no documentation to indicate a 2 step Mantoux had been administered prior to or upon admission for Resident 1. 2. The clinical record for Resident 2 was reviewed on 11/15/19. Diagnoses included, but were not limited to, muscle weakness and heart failure. There was no documentation to indicate a 2 step Mantoux had been administered prior to or upon admission for Resident 2. 3. The clinical record for Resident 5 was reviewed on 11/15/19. Diagnoses included, but were not limited to, type 2 diabetes and anxiety. There was no documentation to indicate a 2 step	R 0410	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 1, 2, 5, and 8 will not be affected by this alleged deficient practice. Residents 1, 2, 5, and 8 will be administered a first step Mantoux test and a second step Mantoux test 1-3 weeks after receiving the first step, then annually thereafter while residing in the facility. Administration of first step, second step, and annual Mantoux's will be documented in the resident's clinical record. If a Mantoux test is contraindicated for a resident a chest x-ray will be obtained. MD and POA for residents 1, 2, 5, and 8 will be notified of this alleged deficient practice and documentation will occur in the resident's clinical record. **How other residents having the potential to be affected by the same deficient practice will be**	12/15/2019

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	Mantoux had been administered prior to or upon admission for Resident 5. 4. The clinical record for Resident 8 was reviewed on 11/15/19. Diagnoses included, but were not limited to, vertigo, anemia, and anxiety. There was no documentation to indicate a 2 step Mantoux had been administered prior to or upon admission for Resident 8. Licensed Practical Nurse (LPN) 1 was interviewed on 11/15/19 at 3:02 P.M. During the interview LPN 1 indicated residents being admitted to assisted living to do not receive a 2 step Mantoux test prior to or upon admission. She also indicated residents receive annual TB (tuberculosis) tests only. The Regional Director of Operations (RDOO) was interviewed on 11/15/19 at 3:55 P.M. During the interview the RDOO indicated there was no documentation indicating the above residents had a 1 or 2 step Mantoux prior to or upon admission and they should have had one. A policy, dated 6/08, was provided by the Administrator on 11/15/19 at 3:55 P.M., titled "Tuberculosis Control Plan" and she indicated it was the policy currently used by the facility. The policy indicated "All residents either prior to or upon admission, in according with date [sic] and federal regulation will receive a 2 step Mantoux test for tuberculosis."		**identified and what corrective action(s) will be taken:** All residents residing in the residential wing have the potential to be affected by this alleged deficient practice. No resident residing in the residential wing will be affected by this alleged deficient practice. An audit will be completed on all residents residing in the residential wing. Any resident found to not have a first step, second step, or annual Mantoux documented will be administered a first step Mantoux test and a second step Mantoux test 1-3 weeks after receiving the first step, then annually thereafter while residing in the facility. Administration of first step, second step, and annual Mantoux's will be documented in the resident's clinical record. If a Mantoux test is contraindicated for a resident a chest x-ray will be obtained. MD and POA for residents found to not have a first step, second step or annual Mantoux test will be notified of this alleged deficient practice and documentation will occur in the resident's clinical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All new admissions will receive a first step Mantoux within 24 hours	

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			of admission to the facility with a second step Mantoux being scheduled 1-3 weeks after. For new admissions with a contraindication for Mantoux skin test a chest x-ray will be obtained. All nursing staff will be in-serviced 12-4-19 relating to Tuberculosis Control Plan Policy and Procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON and/or Designee will audit new admissions the day after admitting on scheduled work days ensuring first step, second step, and annual Mantoux skin test are appropriately scheduled for administration or a chest x-ray if Mantoux is contraindicated. This audit will be conducted on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for 6 months and plan adjusted accordingly if needed (See Attachment C).	