	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION		MB NO. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	î /	LDING	00	COMPLETED	
		155763	B. WING			11/15/2019	
NAME OF F	PROVIDER OR SUPPLIE	CR		STREET	D		
		URSING & REHABILITATION CI	ENTE		AIL RIDGE RD N, IN 46701		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	CTION ULD BE	COMPLETION
TAG	REGULATORY O	PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	PROPRIATE	DATE
0000							
3ldg. 00	This visit was for	a Recertification and State	F 00	00	This plan of correction is	to convo	
		This visit included a State	F 000	00	This plan of correction is		
	Residential Licens				as North Ridge Village N and Rehab's credible all	-	
	Residential Licells	survey.			compliance. Submission	•	
	Survey dates: Nov	vember 7, 8, 12, 13, 14 and 15,			plan of correction does r		
	2019.	· · · · · · · · · · · · · · · · · · ·			constitute an admission		
					Ridge Village Nursing a	•	
	Facility number: (011296			or its management com		
	Provider number: 155763 AIM number: 19112962	155763			the allegations contained	d in the	
		12962			survey report are a true accurate portrayal of the		
	Census Bed Type:				of nursing care and othe		
	SNF/NF: 40				in the facility, nor does t		
	Residential: 12				submission constitute ar		
	Total: 52				agreement or admission	of the	
	~ ~ ~				survey allegations. We		
	Census Payor Typ	e:			respectfully request a pa		
	Medicaid: 29				of this plan of correction	•	
	Other: 23 Total: 52						
	10tal. 32						
	These deficiencies	reflect State Findings cited in					
	accordance with 4	-					
	Quality review cor	npleted November 19, 2019.					
0582	483.10(g)(17)(18						
SS=A		re Coverage/Liability Notice					
3ldg. 00	§483.10(g)(17) T	-					
		ledicaid-eligible resident, in le of admission to the					
		nd when the resident					
	becomes eligible						
	-	d services that are included					
		services under the State					
		the resident may not be					
		- ,			1		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/03/2019

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

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019		ETED
	NAME OF PROVIDER OR SUPPLIER		ENTE	600 TR	ADDRESS, CITY, STATE, ZIP (AIL RIDGE RD N, IN 46701			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	E	(X5) COMPLETIC DATE
	facility offers and be charged, and those services; a (ii) Inform each M when changes at services specifie (B) of this section §483.10(g)(18) T resident before, o and periodically o services availabl charges for those charges for servi Medicare/ Medic diem rate. (i) Where change items and service and/or by the Me must provide not change as soon (ii) Where chang other items and se offers, the facility writing at least 60 implementation of (iii) If a resident of the facility must n resident represent applicable, any of paid, less the fac days the resident or retained a beo any minimum star requirements. (iv) The facility m	Medicaid-eligible resident re made to the items and d in §483.10(g)(17)(i)(A) and h. he facility must inform each or at the time of admission, during the resident's stay, of e in the facility and of e services, including any ces not covered under aid or by the facility's per es in coverage are made to es covered by Medicare dicaid State plan, the facility ice to residents of the as is reasonably possible. es are made to charges for services that the facility must inform the resident in D days prior to						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETIO DATE
	 (v) The terms of a on behalf of an ir to the facility must requirements of t Based on record re failed to ensure 2 of 	discharge from the facility. an admission contract by or advidual seeking admission at not conflict with the hese regulations. eview and interview the facility of 3 residents reviewed received a prior to skilled services being	F 0:	582	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient		12/15/201
	Findings include: On 11/14/19 at 1:2 Residents Dischar form was reviewed	11/14/19 at 1:25 P.M., the Beneficiary Notice- idents Discharged Within the Last Six Months n was reviewed and indicated Resident's 18			practice: Residents 16 and 36 will not any adverse effects related to alleged deficient practice. Residents 16 and 36 will be issued an ABN and NOMNC hours in advance prior to a sk level of care ending.	o this 48	
	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.			How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All residents have the potenti- be affected by this alleged deficient practice. All resident a skilled level of care stay will issued an ABN and NOMNC	ne be ve al to rs on l be		
	Protection Notifica following: Reside Part A Skilled Ser There was no docu (Advance Benefic and a NOMNC (N Non-Coverage) wa resident. On 11/14/19 at 1:4	Nursing Facility) Beneficiary ation Review form indicated the nt 36 had received Medicare vices on 8/14/19 to 10/11/19. umentation a SNF ABN ary Notice of Non-Coverage) otice of Medicare as or was not provided to the 7 P.M., an interview was imum Data Set (MDS)			What measures will be put in 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 AB and NOMNC's with BOM/HR Director as back up person. M	r nto N's	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	r í	JILDING	DNSTRUCTION 00	COME	e survey pleted 5/2019
	PROVIDER OR SUPPLIE RIDGE VILLAGE N	R URSING & REHABILITATION CI	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP CO CAIL RIDGE RD N, IN 46701	D	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	SNF Beneficiary P Resident 18 and Re On 11/14/19 at 2:4 Resources indicate documentation that had been given a 2 services ending. On 11/14/19 at 2:4 conduct with the H and requested the	Itant indicated there were no rotection Notification for esident 36. 2 P.M., an interview with Human d she could not find any c Resident 18 and Resident 36 day notice prior to their skilled 4 P.M., an interview was ealth Facility Administrator policy for SNF Beneficiary tion which was not provided.			Coordinator and BOM/H will be in-serviced 12-4- regarding policy and pro relating ABN's and NOM How the corrective acti will be monitored to en deficient practice will n recur: Administrator and/or De- monitor all ABN's and N monthly for 6 months, th quarterly thereafter. Any findings will be corrected immediately and forward Regional MDS Consulta report of progress will be to the QA Committee mo 6 months and plan adjus accordingly (See Attach	19 cedures INC's. on(s) sure the ot signee will OMNC's en negative ded to the nt. A e forwarded onthly for sted	
⁶ 0623 SS=A Bldg. 00	Transfer/Discharg §483.15(c)(3) No Before a facility tr resident, the facil (i) Notify the resid representative(s) and the reasons f a language and n facility must send representative of Long-Term Care (ii) Record the read discharge in the r accordance with section; and	ce Requirements Before hsfer/Discharge 3.15(c)(3) Notice before transfer. ore a facility transfers or discharges a dent, the facility must- lotify the resident and the resident's esentative(s) of the transfer or discharge the reasons for the move in writing and in hguage and manner they understand. The ity must send a copy of the notice to a esentative of the Office of the State g-Term Care Ombudsman. Record the reasons for the transfer or harge in the resident's medical record in ordance with paragraph (c)(2) of this					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CON	(X3) DATE SURVEY COMPLETED 11/15/2019	
	NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHABILITATION (ENTE	STREET A 600 TR ALBION	COD	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	 (i) Except as spearad (c)(8) of this transfer or discharged. (ii) Notice must be a 30 days before the discharged. (ii) Notice must be practicable before (A) The safety of would be endange (i)(C) of this sect (B) The health of would be endange (i)(D) of this sect (C) The resident to allow a more in discharge, under section; (D) An immediate required by the reneeds, under partice by the reneeds, under partice of this section; or (E) A resident has for 30 days. §483.15(c)(5) Convritten notice spearad for 30 days. §483.15(c)(5) Convritten notice spearad for 30 days. (ii) The reason for (iii) The location transferred or dis (iv) A statement of the section of the sec	individuals in the facility gered, under paragraph (c)(1) ion; s health improves sufficiently mmediate transfer or paragraph (c)(1)(i)(B) of this e transfer or discharge is esident's urgent medical ragraph (c)(1)(i)(A) of this s not resided in the facility entents of the notice. The ecified in paragraph (c)(3) of include the following: or transfer or discharge; date of transfer or discharge; to which the resident is						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	ì í	JILDING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP AIL RIDGE RD N, IN 46701	COD		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(v) The name, ac and telephone nu State Long-Term (vi) For nursing fa intellectual and d related disabilitie address and tele responsible for th of individuals with established unde Developmental D Bill of Rights Act codified at 42 U.S (vii) For nursing f mental disorder of mailing and email number of the ag protection and act	peal hearing request; dress (mailing and email) unber of the Office of the Care Ombudsman; acility residents with evelopmental disabilities or s, the mailing and email phone number of the agency the protection and advocacy in developmental disabilities r Part C of the bisabilities Assistance and of 2000 (Pub. L. 106-402, S.C. 15001 et seq.); and acility residents with a or related disabilities, the I address and telephone ency responsible for the dvocacy of individuals with a established under the dvocacy for Mentally III						
	If the information to effecting the tr facility must upda notice as soon as updated informat §483.15(c)(8) No closure In the case of fac who is the admin provide written no impending closur Agency, the Offic Care Ombudsma and the resident	anges to the notice. in the notice changes prior ansfer or discharge, the ate the recipients of the s practicable once the ion becomes available. tice in advance of facility sility closure, the individual istrator of the facility must otification prior to the te to the State Survey te of the State Long-Term in, residents of the facility, representatives, as well as ransfer and adequate						

TERS FO	R MEDICARE & MEDI	CAID SERVICES				OM	1B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155763	B. W.	NG		11/15	/2019
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	<u></u>	
NORTH	RIDGE VILLAGE N	IURSING & REHABILITATION CE	NTE		RAIL RIDGE RD N, IN 46701		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		residents, as required at §	_				Diff
		residents, as required at §					
	483.70(l).		ГО	(0)			10/15/2014
	Based on record review and interview the facility		F 0	523	What corrective action(s) wi	11	12/15/201
		-			be accomplished for those		
	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 found to have bee	n	
					affected by the deficient		
		-			practice:		
	residents reviewed	.(Resident 23)			Residents 23 will not have an	у	
					adverse effects related to this	;	
	Findings include:				alleged deficient practice.		
	C				Resident 23 and POA will be		
	On 11/12/19 at 10	33 A.M., the Clinical Record of			notified in writing within 24 ho	urs	
		eviewed. Diagnosis included,			of the resident's	uis	
		-					
	but were not limited t pneumonia.	to to, pullionary norosis and			transfer/discharge.		
	phoumonia.				How other residents having	the	
	The SPAP (is on a	cronym for Situation,			_		
		-			potential to be affected by the		
	-	ssment, Recommendation)			same deficient practice will		
		orm dated $8/21/19$ indicated the			identified and what corrective	/e	
		ident had signs of abdominal			action(s) will be taken:		
		non-responsive. Resident 23's			All residents have the potentia	al to	
	Physician had been	n notified and the resident was			be affected by this alleged		
	transferred to the h	nospital emergency room.			deficient practice. All resident	S	
					and their POA will be notified	in	
	There was no docu	mentation the resident or			writing within 24 hours of the		
	resident's represen	tative had been notified of his			resident's transfer/discharge.		
		and provided the appeal rights					
		ting when the resident was sent			What measures will be put in	nto	
	out to the hospital.	6			place and what systemic		1
	out to the hospital.						1
	The most surrant	induced notion titled North			changes will be made to		1
		indated policy titled North			ensure that the deficient		1
		sing and Rehab Bed			practice does not recur:		1
		Policy was received from			All residents and their POA's		1
		on 11/14/19 at 10:30 A.M. The			be notified in writing within 24		1
		ut is not limited to the			hours of the resident's		1
	following: "On ad	mission to the facility, the			transfer/discharge. All nursing) staff	1
		on Director will explain the policy			will be in-serviced 12-4-19		1
		nily or representative and			regarding policy and procedu	res	1
		at (sic) (a) copy of the packet to			relating transfer/discharge of	-	
	-	ords. An acknowledgement of			residents.		
		oras. Thi doknowiougement of			realuenta.		1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	î î	UILDING	onstruction 00	COM	fe survey ipleted 15/2019	
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	ENTE	STREET ADDRESS, CITY, STATE, ZIP CO 600 TRAIL RIDGE RD NTE ALBION, IN 46701)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
- 0625 SS=A Bidg. 00	receipt will be sign resident's chart. T include: a copy of discharge and tran hearing In case notice 'at the time family, surrogate of with written notifit transfer. This requised copy of the notice accompanying the On 11/14/19 at 10 conducted with M had reviewed Resis to find documenta Discharge form has resident's represen On 11/14/19 at 10 conducted with Li indicated the nurse resident's conditio Resident 23's repres Of Transfer Or Di On 11/14/19 at 10 conducted with He indicated the nurse the hospital emerge the resident's represen 3.1-12(a)(6)(A) 483.15(d)(1)(2) Notice of Bed Ho	hed at that time to be kept on the he bed hold packet shall If the policy, notice of transfer or sfer or discharge request for s of emergency transfer, a of transfer' means that the or representative is provided cation within 24 hours of the airement is met if the resident's is sent with other papers resident to the hospital." 46 A.M., an interview, edical Records, indicated she dent 23's record and was unable tion a Notice Of Transfer Or d been provided to the tative. 50 A.M., an interview, censed Practical Nurse (LPN) 2, e who had documented the n should have provided esentative with a written Notice scharge form. 58 A.M., an interview was ealth Facility Administration e who had sent the resident to ency room should had provided esentative in writing a Notice Of			How the corrective ac will be monitored to e deficient practice will recur: D.O.N and/or Designed monitor all transfer/dis- weekly for 8 weeks, the for 4 months, then quat thereafter. Any negativ will be corrected imme forwarded to the Admin report of progress will to to the QA Committee r 6 months and plan adji accordingly (See Attac	e will charges en monthly interly ve findings idiately and nistrator. A be forwarded monthly for usted		

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 11/15/2019	
	TH RIDGE VILLAGE NURSING & REHABILITATION		ENTE	STREET 600 TF ALBIO				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
	nursing facility tra hospital or the re- leave, the nursin information to the representative th (i) The duration of any, during which return and resum facility; (ii) The reserve to state plan, under any; (iii) The nursing fi bed-hold periods with paragraph (ippermitting a resid (iv) The informat (1) of this section §483.15(d)(2) Be At the time of tra hospitalization of facility must prov- resident represen- specifies the dur described in para Based on interview failed to ensure a provided when the to the hospital for (Resident 23) Findings include: On 11/12/19 at 10	of the state bed-hold policy, if the resident is permitted to ne residence in the nursing bed payment policy in the § 447.40 of this chapter, if facility's policies regarding s, which must be consistent e)(1) of this section, dent to return; and ion specified in paragraph (e)	F 0-	525	What corrective action(s be accomplished for the residents found to have affected by the deficient practice: Residents 23 will not have adverse effects related to alleged deficient practice. Resident 23 and/or POA notified of the facilities be policy upon the resident's transfer/discharge.	e any this will be d hold	12/15/20	

	R MEDICARE & MEDIO NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. E	AULTIPLE CO BUILDING VING	DNSTRUCTION 00	(X3) DAT COMI	MB NO. 0938-039 E SURVEY PLETED 5/2019
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	included, but were fibrosis and pneum The SBAR (is an a Background, Asse Communication Fe following: the res distention and was Physician had been transferred to the H There was no docu policy had been pr been sent to the ho The most current u Ridge Village Nur Hold/Readmission Medical Records of policy indicated, b following: "POLH resident to a hospi written informatio member or legal re duration of the beo resident is permitted residence in the fa- transfer, the family will be provided w hours. PROCEDU facility, the Comm explain the policy representative and copy of the packet acknowledgement time to be kept on hold packet shall in cases of emergency	e not limited to, pulmonary nonia. acronym for Situation, ssment, Recommendation) orm dated 8/21/19 indicated the ident had signs of abdominal s non-responsive. Resident 23's n notified and the resident was nospital emergency room.			How other residents have potential to be affected is same deficient practice identified and what corr action(s) will be taken: All residents have the pot be affected by this allege deficient practice. All resident practice. All resident practice. All resident's transfer/dischart What measures will be policy or resident's transfer/dischart What measures will be policy or resident's transfer/dischart What measures will be policy or resident's transfer/dischart practice does not recur: All residents and/or POA notified of the facilities be policy upon the resident's transfer/discharge. All nu will be in-serviced 12-4-1 regarding policy and proce- relating to the facilities be policy. How the corrective action will be monitored to enside deficient practice will no recur: D.O.N and/or Designee v monitor all transfer/dischart weekly for 8 weeks, then for 4 months, then quarter thereafter to ensure the fa- bed hold policy was provin- negative findings will be of immediately and forwarder Administrator. A report of	by the will be ective tential to d dents ed of the upon the arge. but into c bt will be ed hold s rsing staff 9 bedures ed hold s rsing staff s rot	

Event ID: K3VX11 Facility ID: 011296

If continuation sheet Page 10 of 33

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	(X5) COMPLETIO DATE
	requirement is met	24 hours of the transfer. This if the resident's copy of the other papers accompanying the pital."			will be forwarded to the QA Committee monthly for 6 mo and plan adjusted according (See Attachment J).		
	conducted with M had reviewed Resi to find documenta	46 A.M., an interview, edical Records, indicated she dent 23's record and was unable tion a bed hold policy had been ident's representative.					
	conducted License indicated the nurse resident's condition	50 A.M., an interview, d Practical Nurse (LPN) 2, who had documented the n should had provided essentative with a bed hold					
	conducted with He indicated the nurse the hospital should	58 A.M., an interview, ealth Facility Administration, who had sent the resident to had provided a bed hold ent's representative.					
	3.1-12(a)(25)(26)						
⁼ 0658 SS=D Bldg. 00	Standards §483.21(b)(3) Co The services pro facility, as outline care plan, must-	d Meet Professional mprehensive Care Plans vided or arranged by the d by the comprehensive onal standards of quality.					
	Based on interview failed to ensure a l	A and record review the facility A and record review the facility Physician's order was followed reviewed (Resident 25).	F 00	558	What corrective action(s) w be accomplished for those residents found to have be affected by the deficient practice: Resident 25 will not have an	en	12/15/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULT A. BUILI B. WING		(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE RIDGE VILLAGE N	R IURSING & REHABILITATION CE	e	TREET ADDRESS, CITY, STATE, ZIP (00 TRAIL RIDGE RD ALBION, IN 46701	COD	
NORTH (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O The clinical record on 11/7/19 at 11:2: were not limited to 2 diabetes. A Physician's orde Resident 25 was to Protonix daily. There was no docu 25 had received 40 after the medicaito The Director of Nu interviewed on 11/ interview the DNS have been receivin	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION I for Resident 25 was reviewed 3 A.M. Diagnoses included, but b, dementia, heartburn, and type er dated 8/12/19, indicated o receive 40 milligrams of mentation to indicate Resident 0 milligrams of Protonix daily n was ordered on 8/12/19. ursing Services DNS was (14/19 at 1:48 P.M. During the indicated Resident 25 should g 40 milligrams of Protonix after /12/19 and he had not been	ENTE A	ALBION, IN 46701 D PROVIDERS PLAN OF COMPRETENCED TO THE DEFICIENCY AG adverse effects related alleged deficient pract Resident 25 is receivin 40mg daily. How other residents I potential to be affected same deficient practii identified and what car action(s) will be taken All residents have the be affected by this alled deficient practice. An acompleted on physicia the past 30 days. Any findings will result in M notification and docum occur in the resident's record. What measures will be place and what syste changes will be made ensure that the deficient practice does not record. What measures will be made ensure that the deficient practice does not record.	HOULD BE APPROPRIATE d to this ice. ng Protonix having the ed by the ce will be orrective n: potential to eged audit will be in orders for negative 1D and POA hentation will clinical be put into mic e to ient sur: ill be nursing staff 4-19	(X5) COMPLETIC DATE
				will be in-serviced 12-4 regarding policy and p relating to physician of medication administra How the corrective ad will be monitored to a deficient practice will recur: DON and/or Designee all new physician orde scheduled work days f then weekly for 4 weel	rocedures rders and tion. ction(s) ensure the I not e will monitor ers daily on for 8 weeks,	

PRINTED: 12/03/2019 FORM APPROVED OMB NO. 0938-039

	R MEDICARE & MEDI					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155763	A. BUILDIN B. WING	G <u>00</u>		PLETED 5/2019
		155765			-	5/2019
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CO	D	
NODTU) TRAIL RIDGE RD		
NORTH		IURSING & REHABILITATION C	ENTE AL	BION, IN 46701		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAC			DATE
				monthly for 3 months. A		
				negative findings will be		
				immediately and forwar		
				Administrator. A report	1 0	
				will be forwarded to the		
				Committee monthly for		
				and plan adjusted acco (See Attachment D).	raingly	
				(See Allachment D).		
0686	483.25(b)(1)(i)(ii)					
SS=D		o Prevent/Heal Pressure				
Bldg. 00	Ulcer					
0	§483.25(b) Skin	Intearity				
	§483.25(b)(1) Pr					
		nprehensive assessment of				
		cility must ensure that-				
		eives care, consistent with				
	professional star	dards of practice, to prevent				
	pressure ulcers a	and does not develop				
	pressure ulcers u	Inless the individual's clinical				
	condition demon	strates that they were				
	unavoidable; and					
	(ii) A resident wit	h pressure ulcers receives				
	necessary treatm	nent and services, consistent				
		standards of practice, to				
		prevent infection and prevent				
	new ulcers from	developing.				
			F 0686	What corrective action		12/15/201
		ion, record review and		be accomplished for the		
		ity failed to ensure wound care		residents found to hav		
		onsistently documented for 1 of		affected by the deficie	nt	
	2 residents review	ea. (Resident 20)		practice:		
	Lindings in shelts			Resident 20 will not be	-	
	Findings include:			this alleged deficient pro		
	The Clinical Dar-	rd of Pasident 20 was reviewed		Resident 20 will have w		
		rd of Resident 20 was reviewed		treatments documented	upon	
		8 P.M. The resident record		completion.		
	-	s included, but were not limited aralysis of all 4 limbs),		How other residents b	aving the	
	abnormal posture	-		How other residents have potential to be affected	-	
	i annormai nosuire :				ι την τησ	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCT A. BUILDING <u>00</u> B. WING	COMP	e survey leted 5/2019		
	PROVIDER OR SUPPLIE RIDGE VILLAGE N	R IURSING & REHABILITATION CE	STREET ADDRESS, CITY, STATE, ZIP COD 600 TRAIL RIDGE RD ENTE ALBION, IN 46701				
(X4) ID		STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACL CROSS TAG	H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE		
	The quarterly Mini assessment dated 9 was interviewable, assistance of 1 per- transfers. The Nurses Note d indicated the reside hospital. The physician's ord Dated 5/22/19 the his bed, offload the received vitamin C day and received a Dated 6/18/19, was with soap and wate moistened with dal abdominal dressing a day and follow u weeks. Dated 10/15/19 give supplement) 30 mi wound healing. Dated 11/9/19 give The October 2019 Record (TAR) indi to wash Resident 2 and water, pat dry, dakins and cover w wound care on the resident's treatmen the following dates	imum Data Set (MDS) //3/19, indicated the resident and required extensive son for bed mobility and ated 11/11/19 at 10:15 P.M., ent was admitted to the der indicated the following: resident had an air mattress on e resident's heels while in bed, 2 500 milligrams (mg) 2 times a daily vitamin 1 time a day. sh the resident's ischial wounds er, pat dry, insert gauze kins and cover with an g. Change the dressing 2 times p with the wound center in 3 we Remeron 7.5 mg 1 time a day	Same identifiantiant action All resibe affer deficie conduit docum days. A notified docum action What in place chang ensure practic Docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing regard relating docum treatm comple nursing reserve chang ensure reserve reserve treatm comple nursing reserve treatm comple nursing reserve treatm comple nursing reserve treatm comple nursing reserve treatm comple nursing reserve treatm comple nursing reserve treatm comple reserve treatm comple nursing reserve treatm comple comple c	he corrective action(s) e monitored to ensure the ent practice will not			

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	(X3) DAT	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	00	COMPLETED		
		155763	B. W	ING		11/1	11/15/2019	
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP C	COD		
		` URSING & REHABILITATION CI			AIL RIDGE RD N, IN 46701			
		ORSING & REHABILITATION CI		ALDIUI	N, IN 40701			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
		nentation the resident had			will be forwarded to the			
	refused the treatment	nt to his wound.			Committee monthly for			
	The Initial Deserves	Ulcer Assessment form			and plan adjusted accordingly	oraingly		
				(See Attachment E).				
		ving: Resident 20 had a facility essure ulcer to his right						
		at developed on $9/27/19$. The						
		ed weekly on the following						
	dates:							
		ngth was 4.5 centimeters (cm)						
		id 1.8 cm in depth without						
	tunneling or undern	nining.						
	On 10/17/19 the len	ngth was 4.5 cm by 4 cm in						
	width and 1.5 cm in	depth without tunneling or						
	undermining.							
		igth was 4.5 cm by 4 cm in						
		depth without tunneling or						
	undermining.							
		igth was 5 cm by 2 cm in width there was tunneling or						
	-	00 of 1.0 cm with an illegible						
		"er" with a x marked through						
	the "er" followed by	-						
		th was 5 cm by 2 cm in width						
		th tunneling or undermining at						
	12:00 at 1 cm.	0 0						
	On 11/13/19 there v	were no measurements because						
	the resident remained	ed in the hospital.						
	The Physician's Ord	lers dated 10/29/19 at 2:30						
		ident 20 had been seen by the						
		the right ischium measured 5						
	cm in length by 2 cm	m in width and 1.8 cm in depth						
	without tunneling o	r undermining.						
	The care plan for th	e potential for impaired skin						
	<u>^</u>	Resident 20's immobility and						
		itiated on 8/27/13 indicated the						
		rea to his left and right						
	_	s to spend most of the time up						

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155763	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP AIL RIDGE RD N, IN 46701			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	harm to self with i Date initiated: 8/2 Interventions inclu- the following: "TH turn/reposition at I requested. (Reside reposition after he He remains in his days despite contin of risks vs. benefit 8/27/13. Assess/re- weekly. Measure I possible. Assess an perimeter, wound Report improveme Date initiated 8/27 treatment, confer v (Interdisciplinary ' why and try altern compliance. Docu initiated: 8/27/13 inflation every shi Transfer bar for be 1/20/14." On 11/14/19 at 2:4 Director of Nursin was extremely non and sat in his we f DNS indicated the resident's right but incorrectly docum the week prior the and the week after documented as 1.8 On 11/15/19 at 8:5	and de but, were not limited to, the resident needs assistance to least every 2 hours as needed or int 20's name) refuses to is up in his W/C (wheelchair). w/c greater than 12 hrs most nued education with discussion is of his choice. Date initiated: ecord/monitor wound healing ength, width and depth where and document status of wound bed and healing progress. ents and declines to the MD. V13If the resident refuses with the resident , IDT Team) and family to determine ative methods to gain ment alternative methods. Date .Roho cushion in w/c. Check ft. Date initiated 8/14/15. ed mobility. Date initiated: 40 P.M., during an interview the ig (DNS) indicated Resident 20 noompliant with his treatments for long periods of time. The e wound measurement of the tocks, dated 10/23/19 was ented 0.1 cm in depth because depth was documented 1.5 cm 10/23/19 the depth was						

	R MEDICARE & MEDIC				NAME LOWIST		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CO JILDING	NSTRUCTION 00	· /	E SURVEY 'LETED
		155763	B. W	ING		- 11/15/2019	
NAME OF	PROVIDER OR SUPPLIEF	PLIER			ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD		
NORTH	RIDGE VILLAGE N	URSING & REHABILITATION C	ENTE		I, IN 46701		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRC DEFICIENCY)) BE)PRIATE	COMPLET
TAG	wc, and is non com	LSC IDENTIFYING INFORMATION pliant with care.		TAG	DEFICIENCE		DATE
	On $\frac{11}{15}$ or 0.1	A.M., during an interview,					
		esident 20 had refused showers					
		to allow staff to turn the					
		likes to lay on back. The					
		ushion and an air mattress on					
	his bed and wore a						
	On 11/15/19 at 9:23	3 A.M., during an interview,					
		e following: The resident					
	required extensive a	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 usua	ally in bed by 9:30 P.M. and					
	had a sheep skin for	r back when he is sitting up in					
	his wc.						
		1 A.M., during an interview					
		Nurse (LPN) 2 indicated the					
		his treatment at times and					
	and treatments.	ing noncompliant with care					
	On 11/15/19 at 1:14	P.M., during an interview LPN					
	4 indicated Residen	t 20's wound had not been					
		und clinic and thought the					
		vound measurements were					
	because 2 different resident's wound.	nurses had measured the					
	On 11/7/19 at 11:30) A.M., Resident 20 was					
		licated his treatments were					
	done as ordered and	I that he had 7 pressure ulcers					
	and now only had 2						
) A.M., the resident was					
	observed sitting up reducing cushion.	in a wheel chair on a pressure					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	ì í	JILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION CI	ENTE	STREET A 600 TR ALBION	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	Use §483.45(e) Psycl §483.45(c)(3) A p drug that affects with mental proce drugs include, but the following cate (i) Anti-psychotic (ii) Anti-depressa (iii) Anti-anxiety; (iv) Hypnotic Based on a comp resident, the facil §483.45(e)(1) Rep sychotropic drug unless the medic specific condition documented in the §483.45(e)(2) Rep sychotropic drug reductions, and b unless clinically of to discontinue the §483.45(e)(3) Rep sychotropic drug unless that medic a diagnosed speci- documented in the §483.45(e)(4) PF	Psychotropic Meds/PRN notropic Drugs. psychotropic drug is any brain activities associated esses and behavior. These at are not limited to, drugs in egories: ; int; and prehensive assessment of a lity must ensure that esidents who have not used gs are not given these drugs ation is necessary to treat a a s diagnosed and he clinical record; esidents who use gs receive gradual dose behavioral interventions, contraindicated, in an effort					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	r í	JILDING	ONSTRUCTION 00	COMP	X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP 600 TRAIL RIDGE RD ION CENTE ALBION, IN 46701					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETIC DATE	
	physician or press that it is appropri extended beyond document their ra medical record a the PRN order. §483.45(e)(5) PF drugs are limited renewed unless of prescribing pract for the appropria Based on interview failed to ensure 1 of unnecessary medic medications as ord adequate indicatio antipsychotic med Findings include: Resident 31's clini 11/14/19 at 9:23 A admitted to the face but not limited to: disabilities, demer and psychotic disco On 3/27/18, a phys start Resident 31 of medication). On 14 received to decreaa (milligrams) at bed Resident 31's MA record) indicated of 10/13/19 and 10/14	45(e)(5), if the attending acribing practitioner believes ate for the PRN order to be d 14 days, he or she should ationale in the resident's and indicate the duration for RN orders for anti-psychotic to 14 days and cannot be the attending physician or itioner evaluates the resident teness of that medication. v and record review, the facility of 5 residents reviewed for cations (Resident 31), received lered by a physician, and had ns for a dosage increase of an ication. cal record was reviewed on M and indicated he was fility with diagnoses including, moderate intellectual tha with behavior disturbances order with delusions. sician's order was received to on Seroquel (an antipsychotic 0/10/19 a physician's order was se Seroquel from 25 mg dtime to 12.5 mg at bedtime. R (medication administration on 10/10/19, 10/11/19, 10/12/19, 4/19, no Seroquel was given.	F 0'	758	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice: Resident 31 will not have any adverse effects related to this alleged deficient practice. Resident 31 recently returned a hospital stay with Seroquel 50mg ordered. How other residents having potential to be affected by th same deficient practice will identified and what correctiva action(s) will be taken: All residents have the potentia be affected by this alleged deficient practice. An audit wi conducted on all GDR's for th past 6 months. Any negative findings will result in the resid MD and POA being notified a documentation will occur in th resident's clinical record.	n I from the he be re al to II be e ent's nd	12/15/20	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	IULTIPLE CO UILDING /ING	DNSTRUCTION 00	COMP	e survey leted 5/2019
	PROVIDER OR SUPPLIE RIDGE VILLAGE N	R IURSING & REHABILITATION CE	INTE	STREET ADDRESS, CITY, STATE, ZIP COD 600 TRAIL RIDGE RD INTE ALBION, IN 46701			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE	(X5) COMPLETION
TAG	 bedtime to 25 mg a physician's order w Resident 31's Seron mg at bedtime. A progress note da SSD (Social Service 31's family member dose reduction) for the dosage would be a nursing progress indicated: "No adv decreasing Seroque activities." A nursing progress indicated: "No adve Seroquel. Resident and resident noted care". A nurse progress n indicated: "No adv decrease in Seroque A nurse progress n indicated: "No adve be taken. Is not eat than 40%. Does tell A nurse progress n indicated: "Resident at than 40%. Does tell A nurse progress n indicated: "Resident at than 40%. Does tell A nurse progress n indicated: "Resident care". 	R LSC IDENTIFYING INFORMATION at bedtime. On 10/28/19, a vas received to increase quel from 25 mg at bedtime to 50 ted 10/11/19, written by the ce Director) indicated Resident er was informed a GDR (gradual 'Seroquel had occurred, and be 12.5 mg. 5 note from 10/15/19, at 2:47 PM erse effects noted due to el. No change in mood or daily rse effects noted to decreasing 's brother here to visit this shift smiling and cooperative with ote from 10/17/19 at 4:59 PM erse reactions noted to el. Will continue to monitor". ote from 10/20/19 at 12:58 PM riter is voicing concern of lemeanor. Is becoming re and when blood sugar is to ing much at meal times-less Il writer this AM that 'it hurts'." ote fro 10/21/19 at 10:36 AM nt refused lab draws x 3 this hands at writer and yelling 'No!' cplaining procedures."		TAG	What measures will be puplace and what systemic changes will be made to ensure that the deficient practice does not recur: GDR's will be completed ti all residents receiving Psychotropic Drugs, unless previously contraindicated resident's physician. Appro behavior documentation w on all resident's receiving Psychotropic Drugs. All sta be in-serviced on 12-4-19 regarding policy and proce relating to the Behavior Management Program. In all nursing staff will be in-s on 12-4-19 regarding polic procedures relating to GDF documentation. How the corrective action will be monitored to ensure deficient practice will not recur: SSD and/or Designee will dosage and behaviors dail scheduled work days for al residents currently attempt GDR on psychotropic drug weeks, then weekly times - weeks, then monthly on-go Any negative findings will b immediately corrected and forwarded to the Administr report of progress will be for to the QA Committee for 6 and plan adjusted accordin	mely on s by the opriate ill occur aff will dures addition, erviced y and R's and a (s) re the monitor y on ll monitor y on ll s for 4 4 bing. be ator. A prwarded months	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K3VX11 Facility ID: 011296

If continuation sheet Page 20 of 33

PRINTED: 12/03/2019 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		UILDING	nstruction 00	CO	te survey mpleted 15/2019		
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	ENTE	STREET ADDRESS, CITY, STATE, ZIP C 600 TRAIL RIDGE RD ENTE ALBION, IN 46701			DD		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETI		
TAG		R LSC IDENTIFYING INFORMATION ge reduction of Seroquel this		TAG	DEFICIENCY)		DATE		
	were noted before	notes regarding Seroquel use the increase on 10/28/19 from to 50 mg at bedtime.							
	conducted with the had no documenta	:04 AM, an interview was e SSD. The SSD indicated she tion to show why Resident 31's eased from 12.5 mg to 25 mg on							
	10/15/19. The SSI Resident 31's was from 25 mg at bed	D indicated she did not know again increased on 10/28/19 time to 50 mg at bedtime. The							
	nursing progress n Nursing Aides) be The SSD provided	avior tracking is done on otes and CNA (Certified havior management records. I behavior management records							
	indicated two beha On 10/18/19, Resi	ted October 2019 which avior episodes for the month: dent 31 refused labs/swatting at vach used was explained							
	effective; 10/21/19 fingers for blood s	esident and was noted to be b, Resident 31 refused to give ugar and the approach used dication review with the							
	MD/Psych doctor	and was noted to be effective.							
	conducted with Re who indicated the to show Resident 2	16 PM, an interview was egional Director of Operations facility had no documentation B1 received any dosage of 0/10 through 10/15/10. The							
	Regional Director document which v record, dated 10/2	9/19 through 10/15/19. The of Operations provided a vas not part of Resident 31's 5/19, titled 24 hour/change of							
	indicated Resident The Director of O	or multiple residents, which 31 had increased behaviors. perations did not have any other licating Resident 31 was having							

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	r í	VILDING	DNSTRUCTION 00	COMPL	te survey Mpleted 15/2019	
	ROVIDER OR SUPPLIE RIDGE VILLAGE N	R URSING & REHABILITATION C	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701	IL RIDGE RD		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
F 0770 SS=D Bldg. 00	10/28/19. The Regional Direpolicy titled Antips revised 2/2013. Un Implementation, 6. document, and rep- information regard interventions, inclu- medications. 7. Bar symptoms and ove determine whether existing antipsycho 3.1-48(b)(2) 483.50(a)(1)(i) Laboratory Servic §483.50(a)(1)(i) Laboratory Servic §483.50(a)(1) Th- obtain laboratory of its residents. T the quality and tir (i) If the facility pr services, the servic applicable require specified in part 4 Based on interview failed to ensure lab ordered for 1 of 6 m 15). Findings include: The clinical record on 11/13/19 at 2:28	sed on assessing the resident's rall situation, the Physician will to continue, adjust, or stop otic medication. "	F 07	770	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice: Resident 15 will not have any adverse effects related to this alleged deficient practice. ME POA will be notified and BMF be obtained. How other residents having	en S) and) will	12/15/201	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	-	MB NO. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	UILDING	00	ì í	PLETED
		155763		VING	<u></u>		5/2019
					-		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					AIL RIDGE RD		
		URSING & REHABILITATION CE		ALBIO	N, IN 46701		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	r dated 2/9/19, indicated			potential to be affected by		
		have a complete blood count			same deficient practice w		
	· · ·	est every 6 months in January			identified and what correct	ctive	
	and July.				action(s) will be taken:		
	TTI 1				All residents have the pote	ntial to	
		mentation indicating a CBC			be affected by this alleged		
	laboratory test had	been completed in July, 2019.			deficient practice. An audit		
	The Regional Dira	ctor of Operations (RDOO) was			conducted on labs for the p months. MD and POA will		
		15/19 at 12:43 P.M. During the					
		O indicated Resident 15 should			notified of any negative find and lab will be obtained.	unga	
		boratory test in July, 2019 and					
	she had not had one						
	She had not had on				What measures will be pu	t into	
	A Physician's order dated 10/2/19, indicated Resident 15 was to have a CBC and basic				place and what systemic		
					changes will be made to		
	metabolic panel (B				ensure that the deficient		
	I (,			practice does not recur:		
	A laboratory report	provided by the Regional			All lab orders will be obtain	ed in a	
	• •	ons (RDOO) on 11/15/19 at 2:46			timely manner. All nursing	staff to	
	P.M., indicated Res	sident 15 had a CBC on 10/4/19.			be in-serviced 12-4-19 reg		
	The report also ind	icated the phlebotomist was			policy and procedures rela	-	
	unable to obtain the	e BMP on 10/4/19 and a			laboratory management.		
	second phlebotomi	st would be sent to collect the					
	lab.				How the corrective action	(s)	
					will be monitored to ensu	re the	
		mentation indicating a BMP			deficient practice will not		
	had been collected	after 10/4/19.			recur:		
					DON and/or Designee will		
		terviewed on 11/15/19 at 12:43			existing lab orders and new		
	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.				orders weekly for 8 weeks,		
					monthly thereafter. Any ne	gative	
					findings will be corrected		
					immediately and forwarded		
					Administrator. A report of p	-	
		015, was provided by the			will be forwarded to the QA		
		9 at 2:14 P.M., titled "Laboratory			Committee monthly for 6 m		
		she indicated it was the policy			and plan adjusted accordin	gıy	
		he facility. The policy indicated			(See Attachment G).		
	Residents requirin	g laboratory services will					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K3VX11 Facility ID: 011296

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PRINTED: 12/03/2019 FORM APPROVED

OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	r í	JILDING	NSTRUCTION 00	CO	(X3) DATE SURVEY COMPLETED 11/15/2019		
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP AIL RIDGE RD I, IN 46701	COD	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 0883	that the utilization diagnosis, treatment maximized. The far and timely laborate	nd timely laboratory services so of laboratory testing for nt, prevention, or assessment is acility is responsible for quality ory services whether or not led by the facility or an outside							
SS=D Bldg. 00	Influenza and Pn §483.80(d) Influe immunizations §483.80(d)(1) Inf develop policies that- (i) Before offering each resident or receives educatio potential side effe (ii) Each resident immunization Oc annually, unless medically contrai already been imm period; (iii) The resident representative ha immunization; an (iv)The resident's documentation th the following: (A) That the resident regarding the ben effects of influenz (B) That the resident influenza immuni	as the opportunity to refuse d s medical record includes nat indicates, at a minimum,							

	Image: rement of deficiencies X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155763		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019	
	ROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION or refusal		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETIC DATE	
	§483.80(d)(2) Pro facility must deve to ensure that- (i) Before offering immunization, ear representative re the benefits and immunization; (ii) Each resident immunization, un medically contrai already been imm (iii) The resident representative ha immunization; an (iv)The resident representative ha immunization; an (iv)The resident representative wa regarding the bea effects of pneum (B) That the resid pneumococcal in receive the pneu to medical contra Based on interview failed to ensure 1 of reviewed, were offi immunizations in a Findings include: 1. Resident 25's cl 11/15/19 at 12:10 had received a dos	eumococcal disease. The elop policies and procedures g the pneumococcal ch resident or the resident's ceives education regarding potential side effects of the is offered a pneumococcal less the immunization is ndicated or the resident has nunized; or the resident's as the opportunity to refuse d medical record includes nat indicates, at a minimum, dent or resident's as provided education nefits and potential side pococcal immunization; and dent either received the nunization or did not mococccal immunization due indication or refusal.	F 03	383	What corrective action(s) w be accomplished for those residents found to have be affected by the deficient practice: Resident 25 will not have an adverse effects related to thi alleged deficient practice. Resident 25 will receive a pneumococcal vaccine per t most recent CDC guidelines consent is given. Resident a	en y s he , if	12/15/20	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155763	B. W.	ING		11/15	/15/2019	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					AIL RIDGE RD			
NORTH	RIDGE VILLAGE N	IURSING & REHABILITATION (CENTE	ALBION	I, IN 46701			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		, Resident 25 signed an			POA will be provided with			
	· · ·	neumococcal immunization.			education related to the vac	cine		
	Resident 25 did no	t receive a pneumococcal			and an up-dated			
	immunization after	admission to the facility.			consent/declination will be s	igned		
					prior to administration.			
	On 11/15/19 at 1:4	0 PM, an undated policy was			Documentation will occur in	the		
	received from the	Administrator titled			resident's clinical record.			
	"Pneumococcal Va	ccine". The policy indicated			-			
		the pneumococcal vaccination			How other residents havin	a the		
		vill be made in accordance with			potential to be affected by	-		
		Disease Control and			same deficient practice wil			
		recommendations at the time of			identified and what correct			
		DC recommends a single dose			action(s) will be taken:			
		al vaccine for persons 65 years			All residents have the poten	tial to		
	-	ho have not been previously			be affected by this alleged			
		se vaccination status is				uill bo		
					deficient practice. An audit v			
	unknown. A onetin				conducted on all residents r	-		
		persons 65 years and older who			to the pneumococcal vaccin	-		
		r the first time when they were			negative findings will result	n		
		younger and it has been 5 or			administration of the			
	more years since the	ne 1st dose.			pneumococcal vaccine, edu			
					provided to POA and/or resi	dent,		
		the Director of Operations on			and an up-dated			
		M indicated the policy provided			consent/declination will e sig			
		nt one they could locate and			prior to administration of the			
	indicated Resident	25 should have received the			vaccine. Documentation will	occur		
	-	cines according to the CDC			in the resident's clinical reco	ord.		
	recommendations.							
					What measures will be put	into		
	3.1-13(a)				place and what systemic			
					changes will be made to			
					ensure that the deficient			
					practice does not recur:			
					All new admissions will sign	а		
					consent/declination for			
					administration of the			
					pneumococcal vaccination.	lf		
					consent to receive the vacci			
					given, then the POA and/or	-		
					resident will be provided edu	ucated		
						Joaroa		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155763		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE	R IURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETIO DATE
					related to the vaccine and the resident will be administered th vaccine in a timely manner and documentation will occur in the resident's clinical record. All nursing staff will be in-serviced 12-4-19 regarding the policy a procedures relating to the pneumococcal vaccination. How the corrective action(s) will be monitored to ensure t deficient practice will not recur: DON and/or Designee will aud new admissions the day after admitting on scheduled work of ensuring pneumococcal vaccinations are administered timely manner once consent/declination is received This audit will be conducted on-going. Any negative finding will be corrected immediately a forwarded to the Administrator report of progress will be forwat to the QA Committee monthly 6 months and plan adjusted accordingly if needed (See Attachment H).	d d on and he lit days in a d. d. s and . A arded	
R 0000							
Bldg. 00	Survey. This visit State Licensure Su	a State Residential Licensure included a Recertification and arvey. vember 7, 8, 12, 13, 14 and 15,	R 0	000	This plan of correction is to se as North Ridge Village Nursing and Rehab's credible allegatio compliance. Submission of this plan of correction does not constitute an admission by No	g in of s	

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED	
		155763	B. W	ING		11/15/		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COI)		
		URSING & REHABILITATION C	ENTE		RAIL RIDGE RD N, IN 46701			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE ROPRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE	
					Ridge Village Nursing an			
	Facility number: (012931			or its management comp	-		
	D 11 CIG	10			the allegations contained			
	Residential Census	s: 12			survey report are a true a			
					accurate portrayal of the	•		
		ential Findings are cited in			of nursing care and other			
	accordance with 4	IV IAC 10.2-3.			in the facility, nor does th submission constitute an			
	Quality review con			agreement or admission				
	Quality review con	inpleted November 19, 2019.			survey allegations. We			
					respectfully request a pa	per review		
					of this plan of correction.	porretion		
R 0117	410 IAC 16.2-5-1							
	Personnel - Defic	-						
Bldg. 00	. ,	sufficient in number,						
		d training in accordance with aws and rules to meet the						
		nour scheduled and						
	,	eds of the residents and						
		d. The number, qualifications,						
		aff shall depend on skills						
	-	de for the specific needs of						
	the residents. A r	ninimum of one (1) awake						
	staff person, with	current CPR and first aid						
	certificates, shall	be on site at all times. If						
		residents of the facility						
		residential nursing services						
		of medication, or both, at						
		sing staff person shall be on						
		Residential facilities with						
		d (100) residents regularly						
	-	tial nursing services or medication, or both, shall						
		(1) additional nursing staff						
		id on duty at all times for						
		fifty (50) residents. Personnel						
	-	only those duties for which						
	-	o perform. Employee duties						
		h written job descriptions.						

STATEMEN	T OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHABILITATION CE		ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	r.	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on interview failed to ensure sta site consistently. T 12 of 12 residents Findings include: On 11/15/19 at 12: provided the comp CPR (cardiopulmo Aid-Work Tool" d The Residential CL indicated a first aid on site during the f 11/9/19 and 11/10, 11/8, 11/9, 11/10, shift on 11/6/19 ar The Human Resource I nurses who had CL She also indicated from 11/6/19 to 11 staff member was The policy for assi was requested on 1 titled "First Aid Tr	v and record review, the facility off certified in first aid were on This had the potential to affect residing in the facility. 445 PM, the Administrator bleted form titled "Residential onary resuscitation)/First ated 11/6/19 to 11/12/19. PR/First Aide Work Tool d certified staff member was not following shifts: first shift on /19, second shift on 11/6, 11/7, 11/11, and 11/12, 2019, and third id 11/10/19. arce Director was interviewed on P.M. During the interview the Director indicated she thought PR also had first aid training. there had been multiple shifts /12/19 when a first aid certified not on site at the facility. sted living staff qualifications 11/15/19 at 1:50 PM. The policy reatment," revised April 2010, st aid certification requirements	R 0		What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice: No resident residing in the residential wing will be affect this alleged deficient practice. Staff assigned to the resider wing will be CPR and First A Certified. How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken: All residents residing in the residential wing have the pot to be affected by this alleged deficient practice. No reside residing in the residential wing have the pot to be affected by this alleged deficient practice. No reside residing in the residential wing have the pot to be affected by this alleged deficient practice. No reside residing in the residential will be affected by this alleged deficient practice. Audit will completed on all nursing star related to CPR and First Aid Certifications. Staff assigned the residential wing will be C and First Aide Certified. What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff and HR Dire will be in-serviced on 12-4-1 related to CPR and First Aid Certifications. HR Director we monitor new hires for CPR and First Aid Certifications.	en ted by e. itial ide g the the l be ive tential d nt ng will oe ff e d to :PR into	12/15/2019

State Form

Event ID: K3VX11 Facility ID: 011296 If continuation sheet Page 29 of 33

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	INT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER 155763		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 11/15/2019	
	PROVIDER OR SUPPLIE RIDGE VILLAGE N	R R IURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP C AIL RIDGE RD N, IN 46701	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE IPPROPRIATE	(X5) COMPLETION DATE	
		IARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION			First Aide Certifications How the corrective ac will be monitored to e deficient practice will recur: HR Director and/or Des monitor nursing staff ar hires for the nursing de for CPR and First Aide Certifications monthly of DON and/or Designee daily on scheduled wor staff assigned to the re wing are CPR and First Certified for 60 days, th times 4 weeks, then mo thereafter. Any negativ will be corrected immed forwarded to the Admir report of progress will b to the QA Committee n 6 months and plan adju accordingly if needed (Attachment A and B).	tion(s) nsure the not signee will nd new epartment on-going. will monitor k days that sidential t Aide nen weekly onthly e findings diately and nistrator. A be forwarded nonthly for usted		
R 0410 Bldg. 00	completed within admission or upo forty-eight (48) to result shall be red induration with th by whom adminis (f) For residents documented neg result during the months, the base	- Noncompliance tuberculin skin test shall be three (3) months prior to n admission and read at seventy-two (72) hours. The corded in millimeters of e date given, date read, and						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/15/2019		
	PROVIDER OR SUPPLIE	R NURSING & REHABILITATION C	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETIO DATE
	performed within after the first test testing will deper with tuberculosis (g) All residents of to the tuberculin have a chest x-ra laboratory exami a diagnosis. Based on interview failed to ensure re- tuberculosis screen residents reviewed Resident 5, and Re- Findings include: 1. The clinical rec- on 11/15/19. Diag limited to, hyperte muscle weakness. There was no docu Mantoux had been admission for Res 2. The clinical rec- on 11/15/19. Diag limited to, muscle There was no docu Mantoux had been admission for Res 3. The clinical rec- on 11/15/19. Diag limited to, muscle	who have a positive reaction skin test shall be required to ay and other physical and nations in order to complete w and record review the facility sidents were receiving hing upon admission for 4 of 4 I (Resident 1, Resident 2, esident 8). ord for Resident 1 was reviewed noses included, but were not nsion, type 2 diabetes and umentation to indicate a 2 step a administered prior to or upon ident 1. ord for Resident 2 was reviewed noses included, but were not weakness and heart failure.	R 0	410	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice: Residents 1, 2, 5, and 8 will n be affected by this alleged deficient practice. Residents 7 5, and 8 will be administered 3 first step Mantoux test and a second step Mantoux test 1-3 weeks after receiving the first then annually thereafter while residing in the facility. Administration of first step, second step, and annual Mantoux's will be documented the resident's clinical record. I Mantoux test is contraindicate 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 deficien practice and documentation w occur in the resident's clinical record. How other residents having potential to be affected by th same deficient practice will	n lot 1, 2, a step, d in lf a ed for e nt vill the ne	12/15/203

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	ì í	JILDING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/15/2019
	PROVIDER OR SUPPLIEF	R RSING & REHABILITATION CE	INTE	600 TR	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701	
NORTH (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Mantoux had been admission for Resid 4. The clinical reco on 11/15/19. Diagn limited to, vertigo, There was no docum Mantoux had been admission for Resid Licensed Practical 1 on 11/15/19 at 3:02 1 indicated resident living to do not reco prior to or upon adu residents receive ar only. The Regional Direct interviewed on 11/1 interview the RDO0 documentation indi	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION administered prior to or upon dent 5. rd for Resident 8 was reviewed oses included, but were not anemia, and anxiety. mentation to indicate a 2 step administered prior to or upon dent 8. Nurse (LPN) 1 was interviewed P.M. During the interview LPN is being admitted to assisted eive a 2 step Mantoux test mission. She also indicated unual TB (tuberculosis) tests tor of Operations (RDOO) was 15/19 at 3:55 P.M. During the O indicated there was no cating the above residents had ux prior to or upon admission	ENTE			e ntial will be a a al bux ux the fter in fa d for
	Administrator on 1 "Tuberculosis Cont was the policy curr policy indicated "A upon admission, in	8, was provided by the 1/15/19 at 3:55 P.M., titled rol Plan" and she indicated it ently used by the facility. The Il residents either prior to or according with date [sic] and vill receive a 2 step Mantoux s."			residents found to not have a f step, second step or annual Mantoux test will be notified of alleged deficient practice and documentation will occur in the resident's clinical record. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: All new admissions will receive first step Mantoux within 24 ho	e to

If continuation sheet Page 32 of 33 Event ID: K3VX11 Facility ID: 011296

	OF HEALTH AND HU MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE COMPI 11/15	LETED	
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHABILITATION CE			ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701	•	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) of admission to the facility with second step Mantoux being scheduled 1-3 weeks after. For new admissions with a contraindication for Mantoux s test a chest x-ray will be obtain All nursing staff will be in-servi 12-4-19 relating to Tuberculos Control Plan Policy and Procedure. How the corrective action(s) will be monitored to ensure to deficient practice will not recur: DON and/or Designee will auco new admissions the day after admitting on scheduled work of ensuring first step, second ste and annual Mantoux skin test appropriately scheduled for administration or a chest x-ray Mantoux is contraindicated. Th audit will be conducted on-goin Any negative findings will be	n a or kkin ned. iced is s the dit days p, are v if his	(X5) COMPLETION DATE
					corrected immediately and forwarded to the Administrator report of progress will be forwa to the QA Committee monthly 6 months and plan adjusted accordingly if needed (See Attachment C).	arded	

If continuation sheet

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