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| | 155721 | A. BUILDING 00<br>B. WING | 05/21/2018 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00261011.<br><br>Complaint IN00261011 - Unsubstantiated. Due to lack of sufficient evidence.<br><br>Survey dates: May 14, 15, 16, 17, 18, and 21<br><br>Facility number: 000383<br>Provider number: 155721<br>AIM number: 100289610<br><br>Census Bed Type:<br>SNF/NF: 35<br>Total: 35<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 32<br>Other: 2<br>Total: 35<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 29, 2018. | F 0000 | Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 6-20-18. | |
| F 0623<br>SS=D<br>Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge<br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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 | | | |

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

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| | 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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(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.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(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<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: | | | |

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| | (i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(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 submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(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<br>(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.<br><br>§483.15(c)(6) Changes to the notice.<br>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. | | | |

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| | §483.15(c)(8) Notice in advance of facility closure<br>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 relocation of the residents, as required at § 483.70(l). | | | |
| | Based on interview and record review the facility failed to notify in writing to the resident and ombudsman the reason for a transfer to the hospital for 1 of 4 residents reviewed for hospitalization (Resident 24).<br><br>Finding include:<br><br>An interview with Resident 24, on 5/14/18 at 1:40 p.m., indicated the resident had recently been hospitalized for breathing problems.<br><br>Review of the record for Resident 24, on 05/16/18 9:56 a.m., indicated the resident's diagnoses included, but were not limited to, heart failure, atrial fibrillation, shortness of breath, congestive heart failure, major depression disorder, chronic kidney disease, hypertension, dysphagia, and diabetes. The Annual Minimum Data Set (MDS) assessment, dated 3/26/18, indicated the resident was moderately impaired for daily decision making , the resident had went to an acute hospital.<br><br>The physician's order for Resident 24, dated 1/27/18 (no time), indicated the resident may be seen at the hospital related to shortness of breath.<br><br>The record review,dated 2/1/18, indicated | F 0623 | F623<br>Resident 24 returned to the facility from the hospital stay as anticipated. Licensed nursing staff and nurse administration were inserviced on 6-8-18 regarding Notification of Transfer and Discharge, documentation of reason for transfer, and notification of area Ombudsman.<br><br>All resident transfers and discharges during the past 30 days were reviewed for reason of transfer documentation and notification of area ombudsman and additions/corrections made as needed.<br><br>The facility notice of discharge and transfer policy, including reason for discharge, and notification of Ombudsman, was provided at each nurses' station. Licensed nursing staff and nurse administration were inserviced on 6-8-18 regarding Notification of Transfer and Discharge, | 06/20/2018 |

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| | Resident 24 returned back to the facility from the hospital stay on 1/27/18.<br><br>An interview with the Administrator, on 5/17/18 at 2:11 p.m., indicated the facility did not provide Resident 24 or the ombudsman with documentation of the reason for the transfer to the hospital on 1/27/18.<br><br>3.1-12(a)(6)(A) | | documentation of reason for transfer, and notification of area Ombudsman. Residents and or resident representatives will be notified of discharge and transfer, reason for transfer, and said notification will be maintained in the medical record. The area Ombudsman has requested all voluntary transfers and discharge notices be forwarded monthly to his attention.<br><br>The director of nursing or designee will audit transfer information and accompanying documentation, including reason for transfer, prior to transfer when anticipated; and conduct a post-transfer audit of information and accompanying documentation, including reason for transfer, for each resident transfer for three months and weekly for an additional three months. The administrator will maintain a log of the monthly notification of the Ombudsman ongoing. An audit log of findings will be maintained. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0641 SS=D | 483.20(g)<br>Accuracy of Assessments | | | |

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| Bldg. 00 | §483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on record review and interview, the facility failed to accurately document the type of facility a resident returned from and pain medication on the Minimum Data Set (MDS) assessments for 2 of 18 residents reviewed for accurate MDS assessments (resident 36 & 14).<br><br>Findings include:<br><br>1. A review, on 5/15/18 at 11:06 a.m., of resident 36's clinical record indicated the resident diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, bipolar disorder, paranoid schizophrenia, essential hypertension, and insomnia.<br><br>Resident 36's nurses notes, dated 1/18/18 at 6:30 p.m., indicated "Resident alert and oriented x [times] 1, lung sounds clear, all lobes, non-productive cough, bowel sounds present x 4 quadrants, abdomen soft non-tender resident had large amount of emesis(bile), resident states that she doesn't "feel well", increased temperature 101.0, heart rate 85, B/P 184/103, respirations 18, O2 sats 94%, ... This writer notified NP/Physician and received new order to send to hospital for evaluation and treatment, family member aware..."<br><br>Nurse's notes, dated 1/26/18 at 7:00 p.m., indicated the "resident is alert and oriented x 1, lung sounds clear, all lobes, bowel sounds x 4 quadrants, vital signs, temperature 98.0, heart rate 76, respirations 18, B/P 140/76, O2 sats 95%, resident denies and pain or discomfort..."<br><br>On 5/18/18 at 12:48 p.m., review of the resident's MDS assessment, dated January 18, 2018, | F 0641 | F641<br>Resident #36's MDS was reviewed and coded appropriately for discharge destination. Resident #14's MDS was reviewed and coded appropriately to reflect the resident's scheduled pain medication regimen.<br><br>All resident MDSs were reviewed to ensure accurate coding as to the type of facility a resident returned from; and accurate coding of residents' pain medication regimen.<br><br>Pertinent charting and most recent physician orders will be reviewed at the daily morning QA meeting to ensure a discharging facility is identified upon a resident's return to the facility; and new or changed orders related to resident pain and pain management are captured. The MDS person was inserviced by the corporate consulting MDS person on 5-23-18 regarding accurate MDS coding.<br><br>New admissions, residents with a significant change, and resident MDSs due for quarterly review by the interdisciplinary team, will be audited by the MDS person for accurate coding of the type of facility a resident returned from; and pain medication regimen. The | 06/20/2018 |

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| | indicated the resident was hospitalized to an acute care facility.<br><br>Review of the resident's MDS assessment, dated January 25, 2018, indicated the resident was discharged to the facility from a psychiatric hospital.<br><br>On 5/21/18 at 11:47 a.m., an interview with MDS coordinator indicated she could not find where the resident was hospitalized for psychiatric issues. The resident had an urinary tract infection, was placed on anti-biotic, and was returned to facility on 1/25/18, from an acute care facility.<br>2. Resident 14's record was reviewed on 5/16/18 at 3:32 p.m. The record indicated Resident 14 had diagnoses that included, but were not limited to, history of stroke, depression, and chronic pain.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 3/16/18, indicated the resident understands others and was understood by others; he was moderately impaired in cognitive skills for daily decision making and was not on a scheduled pain medication regiment.<br><br>The "Physician's Orders", dated 5/1/18 through 5/31/18, indicated Resident 14 had an order for Acetaminophen 325 milligrams, two tablets by mouth twice a day for chronic pain started on 1/22/16.<br><br>Review of the April and May 2018 Medication Administration Records indicated Resident 14 received the scheduled pain regimen as ordered by the physician.<br><br>Resident 14's care plan, revised on 9/14/16, indicated a focus for "[Resident's name] is at risk | | audits will be conducted for six months and reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | for pain r/t (related to) his stroke hx (history). Goal: [Resident's name] will have any c/o (complaints of) pain relieved with 60 minutes of onset daily by next review. Interventions: Monitor for any c/o or evidence of pain q(every) day. Offer prn pain meds as ordered. Monitor/record response. Offer alternate pain relief measures. Monitor [and] record response. (e.g. Backrub, message, position changes, straightening blankets etc.) Position or comfort as needed. Report any unrelieved pain to md daily prn."<br><br>During an interview, on 5/18/18 at 11:23 a.m., the MDS Coordinator indicated she had "missed it", the resident had received the scheduled pain medication regimen; he was getting routine pain medications and The MDS should have been coded for resident was on a scheduled pain medication regiment.<br><br>3.1-31(g) | | | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the | | | |

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| | participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review the facility failed to update a resident's care plan with current goals and preferences for 1 of 5 residents reviewed for Activities Of Daily Living (ADL). (Resident 2)<br><br>Findings include:<br><br>1.) Review of the record for Resident 2, on 05/16/18 at 12:12 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, muscle weakness, lack of coordination, polyneuropathy, speech disturbances, dysphagia, borderline personality disorder, chronic obstructive pulmonary disease, stress incontinence, schizophrenia and tachycardia.<br><br>The Annual Minimum Data Set (MDS) assessment for Resident 2, dated 5/13/18, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance of one physical staff member for shaving and was totally dependent of one physical staff member for bathing/showers. | F 0657 | F657<br>Resident #2's preference for bathing was clarified and the ADL care plan updated to reflect her current preference for showering.<br><br>All residents' ADL care plans for bathing preferences were reviewed and updated as needed by the MDS coordinator to ensure they reflect the resident's current preference.<br><br>A resident preference sheet, including bathing, will be completed by the resident and/or resident representative upon admission and incorporated in the resident care plan. The interdisciplinary team (IDT) will review resident preferences and resident care plan upon admission, whenever there is significant change, and at least quarterly on a schedule maintained by the MDS | 06/20/2018 |

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| | The preference sheet for Resident 2 (no date), indicated the resident preferred two showers a week on evening shift.<br><br>The ADL care plan for Resident 2, dated 5/5/17 and revision date of 11/07/17, indicated the resident had decreased endurance and hemparesis/hemiplegia. The resident preferred to have a bed bath two times a week and as needed on evening shift. The interventions included, but were not limited to, assist the resident with a bed bath twice weekly and as needed. All Activities of Daily Living (ADL) interventions were dated 5/15/17.<br><br>The care plan lacked the resident's preference of showers.<br><br>An interview with Resident 2, on 05/18/18 11:50 a.m., indicated the resident preferred a shower over a bed bath. "I showered every day at home. I would like to have three showers a week but would be happy with two times a week." The resident at one time had preferred a bed bath because she was fearful of falling in the shower, but that was a long time ago and now she preferred a shower.<br><br>Interview with the MDS Coordinator, on 5/21/18 at 10:26 a.m., indicated Resident 2's care plan for showers had not been updated since her admission in May 2017 and does not reflect her current preference of taking a shower two to three times a week. She was responsible to update the resident's care plan with her current goals and interventions. Social Services would be responsible to complete a preference sheet with the date once a year and as residents goals and preferences changed. | | coordinator. All nursing staff were inserviced on recognizing and recording resident ADL preferences including bathing on 6-8-18.<br><br>The director of nursing or designee will monitor compliance by resident interview and observation; and reviewing bathing sheets and ADL/bathing record-keeping daily for four weeks and weekly for six months. Results of the audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | The care plan policy provided by the MDS Coordinator, on 5/21/18 at 11:20 a.m., indicated the "Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition changes...<br><br>3.1-35(a)(2)(B) | | | |
| F 0677 SS=E Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, interview, and record review the facility failed to assist with showers and provide nail care for 4 of 5 dependent residents reviewed for Activities Of Daily Living (ADL) (Resident 2, Resident 31, Resident 5 and Resident 19).<br><br>Findings include:<br><br>1. An interview and observation with Resident 2, on 5/15/18 at 10:07 a.m., indicated the the resident had not received a shower in a month. The resident had washed herself up some, but it was not the same as having a shower. She had told staff that she would like to have a shower, but staff had not provided them. The resident was suppose to receive showers on Tuesdays and Fridays. The resident had thick white flakes observed in her hair.<br><br>Review of the record for Resident 2, on 5/16/18 12:12 p.m. , indicated the resident's diagnoses included, but were not limited to, hemiplegia, muscle weakness, lack of coordination, polyneuropathy, speech disturbances, dysphagia, | F 0677 | F677<br>Fingernail care was provided for residents # 5 and #31 immediately. The bathing preferences and schedules for residents #5, #31, #2 and #19 were clarified, and the ADL care plans updated as needed.<br><br>All residents' ADL care plans for bathing preferences were reviewed and updated as needed by the MDS coordinator to ensure they reflect the resident's current preference. All residents' fingernails were examined and nail care provided as needed. All MDSs and resident care plans were reviewed to ensure they are an accurate reflection of the resident's level of independence with activities of daily living.<br><br>A resident preference sheet, including bathing, will be | 06/20/2018 |

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| | borderline personality disorder, chronic obstructive pulmonary disease, stress incontinence, schizophrenia, and tachycardia.<br><br>The Annual Minimum Data Set (MDS) assessment for Resident 2, dated 5/13/18, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance of one physical staff member for shaving and was totally dependent of one physical staff member for bathing/showers.<br><br>The preference sheet for Resident 2 (no date) indicated the resident prefers two showers a week on evening shift.<br><br>Review of the shower sheets for Resident 2, indicated the resident did not receive a shower or shaved from 4/1/18 thru 4/9/18. The resident received a bed bath on 4/10/18 and was not shaved, on 4/13/18 the resident refused (no documentation that a shower was offered at a later time), on 4/17/18 the resident received a bed bath and was not shaved, on 4/24/18 the resident received a bed bath and was not shaved, on 4/27/18 the resident refused a shower (no documentation that a shower was offered at a later time) and just wanted her hair washed, on 5/8/18 the resident refused a shower (no documentation that a shower was offered at a later time), on 5/11/18 the resident received a bed bath and was not shaved, and on 5/15/18 the resident received a bed bath and was not shaved. The documentation indicated the resident had not received a shower or had her legs shaved for 45 days.<br><br>An interview and observation with Resident 2, on 05/18/18 11:50 a.m., indicated the resident preferred a shower over a bed bath and showered every day when she was at home. The resident | | completed by the resident and/or resident representative upon admission and incorporated in the resident care plan. The IDT team will review bathing preferences upon admission, whenever a significant change occurs, and at least quarterly on a schedule maintained by the MDS coordinator.<br><br>An assessment of a resident's level of independence with ADLS is documented on the MDS and resident ADL care plan. The interdisciplinary team (IDT) will review a resident's level of independence with ADLs, upon admission, whenever there is a significant change, and at least quarterly on a schedule maintained by the MDS coordinator.<br><br>All nursing staff were inserviced regarding bathing preferences and fingernail care on 6-8-18.<br><br>The director of nursing or designee will monitor compliance by resident interview and observation; and reviewing bathing sheets and ADL/bathing record keeping daily for four weeks and weekly for six months. Charge nurses will examine residents' fingernail care daily for four weeks and weekly for six months. Results of the audits will be reviewed monthly by the QAPI committee overseen by the | |

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| | would prefer to have three showers a week but would be happy with a shower two times a week. She had not been getting bed baths or showers. Her legs were hairy and she could not wear capri pants because it was embarrassing. The resident's bilateral lower legs were observed to have long, thick black, hair on them.<br><br>2. During observation, on 5/14/18 at 2:14 p.m. and 5/15/18 at 12:00 p.m., Resident 31 had long, jagged fingernails with a black substance underneath the nails on both hands.<br><br>During observation, on 5/16/18 at 9:40 a.m., Resident 31 was sitting at the front door of the facility in a wheelchair. The resident's fingernails were long, jagged and had a black substance underneath the nails of both hands.<br><br>During observation, on 5/16/18 at 1:38 p.m., 5/17/18 at 10:10 a.m. and 12:40 p.m., Resident 31 had long, jagged fingernails with a black substance underneath the nails on both hands.<br><br>During observation, on 5/18/18 at 10:53 a.m., Resident 31 was sitting in his wheelchair and had long, jagged fingernails with a black substance underneath the nails on both hands.<br><br>Review of the record for Resident 31, on 05/16/18 at 11:08 a.m., indicated the resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, diabetes, peripheral vascular disease, osteoporosis, osteoarthritis, chronic kidney disease, hyperlipidemia, anxiety, depression, and neuropathy<br><br>The Quarterly MDS assessment for Resident 31, dated 4/18/18, indicated the resident was severely cognitively impaired and required extensive | | administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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assistance of one physical staff member for personal hygiene.

An interview with the Director Of Nursing (DON), on 5/17/18 at 2:50 p.m., indicated Resident 2 had not been receiving showers twice a week as she preferred and Resident 31 had long, jagged dirty fingernails. The CNAs were responsible to keep Resident 31's nails clean and trimmed since he was not a diabetic. The nurse and the CNAs were responsible to ensure residents received showers.
3. Resident 5's record was reviewed on 5/16/18 at 12:24 p.m. His diagnoses included, but were not limited to, dementia and history of cerebral vascular accident with right sided hemiparesis.

Resident 5's Quarterly MDS assessment, dated 2/2/18, indicated he was moderately impaired in his cognitive daily decision making skills and required extensive assistance of one physical staff member for hygiene.

The care plan for Resident 5,revised on 2/21/18, indicated the resident required extensive assistance with his bathing, grooming, and hygiene. He would receive two showers weekly with nail care.

On 5/14/18 at 3:33 p.m., Resident 5 was observed with long fingernails on his left hand with a dark substance underneath all nails and a long thumb nail on his right hand with a dark substance underneath the nail. On 5/17/18 at 10:16 a.m., he was observed to have a dark substance underneath all 5 nails on his left hand and his thumb nail on his right hand.

4. Resident 19's record was reviewed on 5/17/18 at 9:57 a.m. His Quarterly MDS assessment, dated 2/23/18, indicated he was cognitively intact in his

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| | daily decision making skills. He required extensive assistance of one physical staff member for hygiene.<br><br>A care plan for Resident 19, with a revised date of 5/16/18, indicated the resident had a self care performance deficit. He preferred two showers a week and as needed on the evening shift.<br><br>Resident 19's showers were scheduled for Wednesday and Saturday on evening shift. His shower documentation indicated he had received a bed bath on 4/18/18, 4/21/18, 5/2/18, and 5/9/18. No bathing documentation was available for Saturday 4/7/18.<br><br>On 5/15/18 at 10:37 a.m., Resident 19 indicated he only received about one shower a month.<br><br>The Care of Fingernails/Toenails procedure, provided by the Administrator, on 5/18/18 at 1:18 p.m., indicated "...The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. ...General Guidelines...Nail care includes daily cleaning and regular trimming...Proper nail care can aid in the prevention of skin problems around the nail bed...."<br><br>The Shower/Tub Bath procedure, provided by the Administrator, on 5/18/18 at 1:18 p.m., indicated "...The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin...The following should be recorded on the resident's ADL record and/or in the resident's medical record...If the resident refused the shower/tub bath, the reason(s) why and the intervention taken...." | | | |

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| | 3.1-38(a)(2)(A) | | | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>Based on observation, interview, and record review, the facility failed to provide restorative nursing services for 2 of 3 resident's reviewed for range of motion (ROM). (Resident 5 and 16)<br><br>Findings include:<br><br>Resident 5's record was reviewed on 5/16/18 at 12:24 p.m. His diagnoses documented on his May 2018 physician's recapitulation orders included, but were not limited to, vascular dementia and history of cerebral vascular accident (CVA) with right sided hemiparesis.<br><br>Resident 5's Quarterly Minimum Data Set (MDS) assessment, dated 2/2/18, indicated he was | F 0688 | F688<br>Residents #5 and #16 were assessed by the therapy department and their care plans updated as needed regarding care and treatment to prevent loss of range of motion and contracture with measurable objectives and timeframes to meet the resident's medical and nursing needs.<br><br>All residents were assessed by the MDS coordinator and any residents with contracture or limited range of motion were referred to therapy department and | 06/20/2018 |

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| | moderately impaired in his cognitive daily decision making skills. He required extensive assistance of two physical staff members for bed mobility and transfers. He had limited range of motion (ROM) on one side of his upper and lower extremities.<br><br>A restorative plan of care for Resident 5, with a start date of 1/3/18, indicated the resident was at risk for contractures related to a CVA, hemiplegia, and vascular dementia. He was to receive passive range of motion (PROM) to his right upper extremity and have a palm splint and elbow brace. The splint/brace would be applied upon rising and removed at bedtime.<br><br>A restorative plan of care for Resident 5, with a start date of 2/12/18, indicated the resident was at risk for contractures related to a history of contractures. The goal was for the resident to tolerate two sets of ten repetitions of PROM exercises to each joint daily without complaint or signs/symptoms of pain.<br><br>No restorative charting had been documented for Resident 5 since 4/13/18. The facility was unable to provide Resident 5's participation in his restorative programs since 4/13/18.<br><br>On 5/14/18 at 3:29 p.m., Resident 5 was observed with his right hand fingers turned in toward his palm. The resident was not wearing any splint/brace device. The resident indicated he hadn't been doing any type of exercise and hasn't been wearing a splint/brace.<br><br>On 5/17/18 at 12:57 p.m., Certified Nurse Aide (CNA) 6 explained she had just started back as a Restorative Aide this day and had been working as a CNA since the first of April. She had worked | | a screening for treatment was completed for each. The care plans of those with contracture and or limited range of motion were updated as needed including care and treatment of contractures or potential for contracture with measurable objectives and timeframes to meet the residents' medical and nursing needs.<br><br>The director of nursing and MDS coordinator provided 1 to 1 education for C.N.As using the Range of Motion Exercises training tool where each C.N.A. demonstrated their knowledge and competency was documented. Residents requiring the application of splints were identified and training was provided C.N.A.s by therapy. The MDS coordinator and licensed nursing staff were inserviced on 6-8-18 regarding range of motion and documentation.<br><br>The MDS coordinator will monitor the provision of range of motion and the application of splints/orthotics by observation and documentation review daily for four weeks and weekly for six months. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed. | |

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| | part time as a Restorative Aide prior to that and there had been a full time Restorative Aide who had not worked at the facility since the first of April.<br><br>On 5/18/18 at 2:19 p.m., Physical Therapy Assistant (PTA) 7 indicated Resident 5 had been placed on Occupational Therapy (OT) caseload since 2/1/18 and required restorative services for any splinting device by staff since that was not one of OT's goals.<br><br>2. Resident 16's record was reviewed on 5/16/18 at 2:29 p.m. The resident's diagnoses documented on his May 2018 physician's recapitulation orders included, but were not limited to, multiple sclerosis (MS), quadriplegic cerebral palsy, and muscle spasms. The resident's order, dated 12/6/17, indicated for gentle ROM to both hands and wrist with a.m. care prior to applying both hand splints. Apply both hand splints directly with a.m. care and remove both hand splints every four hours.<br><br>Resident 16's Quarterly MDS assessment, dated 3/16/18, indicated he was cognitively intact in his cognitive daily decision making skills. He required extensive assistance of two physical staff members for bed mobility, transfer, dressing, eating, toileting, and hygiene. He had limited ROM to both upper and lower extremities.<br><br>An OT Discharge Summary for Resident 16, dated 12/6/17, indicated a recommendation for a restorative functional maintenance program. The program included, but was not limited to, PROM to his bilateral hands and splint/orthotic care for his bilateral hands to maintain his current level of performance and prevent decline. | | | |

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| | A restorative plan of care for Resident 16, with a start date of 2/13/18, indicated the resident was at risk for contractures related to quadriplegia and MS. The resident was to receive PROM to his bilateral upper extremities after a.m. care and applying hand splints immediately following his PROM. The resident's hand splints were to be removed after six hours.<br><br>A restorative plan of care for Resident 16, with a start date of 3/14/18, indicated the resident was at risk for impaired mobility related to MS, quadriplegia, muscle spasms, and chronic pain. The goal was to complete three sets of ten repetitions of PROM to his bilateral lower extremities and to each joint daily.<br><br>No restorative charting had been documented for Resident 16 since 4/18/18. The facility was unable to provide Resident 16's participation in his restorative programs since 4/18/18.<br><br>On 5/14/18 at 3:55 p.m., Resident 16 was observed lying in a geriatric chair. The resident indicated he had been diagnosed with MS. He thought staff were supposed to exercise his limbs but "they didn't have enough staff to do that."<br><br>On 5/18/18 at 2:23 p.m., Physical Therapy Aid (PTA) 7 indicated the therapy discharge order for Resident 16 had recommended for the resident to be on a restorative PROM and orthotic care to his bilateral hands.<br><br>3.1-42(a)(2) | | | |
| F 0727<br>SS=F<br>Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under | | | |

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| | paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>Based on interview and record review, the facility failed to provide 8 hours of RN coverage for 7 of 31 days reviewed for RN coverage. This had the potential to affect 35 of 35 residents.<br><br>Findings include:<br><br>During an interview with the Director of Nurse (DON), on 5/21/18 at 1:10 p.m., she explained the facility had not had consistent RN coverage at least 8 hours a day.<br><br>During a review of the Direct Care Staff Daily Reports provided by the DON, no RN coverage had been available on 4/22/18, 4/30/18, 5/5/18, 5/6/18, 5/12/18, 5/19/18, and 5/20/18.<br><br>3.1-17(b)(3) | F 0727 | F727<br>To meet the immediate needs of all residents, the facility schedule was adjusted for the coverage of an RN for at least 8 consecutive hours a day, seven days a week.<br><br>To meet the needs of all residents, the facility will schedule for the services of an RN for eight consecutive hours a day, seven days per week.<br><br>The facility will recruit, retain, and otherwise arrange for the services of an RN for eight consecutive hours a day, seven days per week. DON inserviced on 5-21-18 regarding scheduling to meet the requirements for RN coverage.<br><br>The administrator will monitor by reviewing nurse schedule in advance of bi-weekly posting and daily for RN coverage daily for six months and ongoing. Schedules | 06/20/2018 |

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| | | | as worked will be maintained and reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed. | |
| F 0745 SS=D Bldg. 00 | 483.40(d)<br>Provision of Medically Related Social Service<br>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>Based on interview and record review, the facility failed to provide medically related social services to residents who wanted alternative placement and offer dental and optometry services for a resident with missing teeth and blurred vision for 3 of 9 residents reviewed for social services.<br><br>Findings include:<br><br>1. During an interview, on 5/14/18 at 2:56 p.m., Resident 4 indicated he was unhappy here and wants to go somewhere else and no no one has helped him. He said he told the current Administrator and another staff member.<br><br>Resident 4's record was reviewed on 5/17/18 at 2:54 p.m. The record indicated Resident 4's diagnoses included, but were not limited to, seizures, type 2 diabetes, and mood disorder.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 4/26/18, indicated Resident 4 had a severe impairment in cognitive skills for daily decision making and was independent with most activities of daily living. | F 0745 | F745<br>The discharge plans of both residents #13 and #4 were updated and are a current reflection of the assistance being provided and progress with finding alternative placements if appropriate. Resident #30 will be seen by the optometrist and the dentist at their next scheduled visit which Resident #30 finds satisfactory.<br><br>The discharge plan/goals for all residents were reviewed and updates made as needed. Other residents identified as needing optometry or dental services have been scheduled to be seen by the optometrist and dentist at their next visit, or in one case, was seen by an outside dentist previously scheduled.<br><br>The consulting social worker was | 06/20/2018 |

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| | A care plan, with the a revised date of 1/15/18, indicated Resident 4 was "...undecided about ...discharge goals...Social Services will help me explore all of my options and aide me in making a decision about my discharge."<br><br>Social Service (SS) Progress Note, dated 11/16/17 at 3:53 p.m., indicate the "...Resident has been more down within the past few weeks...Residents family is looking into assisted living for resident, family's wish is for [Name of another facility], however at this time they do not have an available unit. Will continue to reach out to alternate AL's(Assisted Livings) for availability...."<br><br>SS progress note, dated12/8/17 at 10:08 a.m., indicated "...Resident and family have inquired about possible assisted living. This writer has sent referral packets out with no acceptance as of today. This writer will continue to work with resident and family for alternative placement that best fits residents needs...."<br><br>SS progress note, dated 1/22/18 at 3:20 p.m., indicated "...Resident wishes to go to an AL. Resident and his family have been educated on the ages that ALF(Assisted Living Facility) that serve. This writer is continuing to work with resident and his family to find alternative placement in which they will be satisfied with...."<br><br>SS progress note, dated 1/31/18 at 1:34 p.m., indicated "This writer received packet from [Name of another facility]. This writer completed pre application for resident. Will return to [Name of another facility] for consideration."<br><br>SS progress note, dated 2/9/18 at 10:56 a.m., indicated "MDS assessment competed for period | | inserviced on the documentation requirements and content of progress notes including a current discharge plan summary when appropriate. The interdisciplinary team (IDT) will review the discharge plan/goal upon admission, whenever there is a significant change, and at least quarterly on a schedule maintained by the MDS coordinator.<br><br>The date and time of all upcoming ancillary provider visits, including optometry and dental, will be posted at the nurses' stations and on the resident bulletin board well in advance of the visits. The schedule of ancillary provider visits will also be announced at Residents' Council. A list of residents who have self-referred or are family or staff referred, will be maintained at the nurses' station and provided to the ancillary provider in advance of their visit. A post follow-up log will be maintained for residents requiring follow up services. Nursing staff were inserviced on 6-8-18 regarding ancillary provider services and the referral process. Families and residents are informed upon admission regarding ancillary practitioner services contracted by the facility.<br><br>New admissions, residents with a significant change, and resident | |

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| | ending 2/9/18. Resident's cognition was severely impaired per BIMs (Brief Interview for Mental Status) assessment...Resident reported feeling down/depressed, having trouble sleeping, and having trouble concentrating. He has had no behaviors during the look back period...He is able to make himself understood with clear speech and understands others conversations. Resident is interested in discharging, but plans are uncertain. Referral was recently made to [Name of another facility]. He prefers not to be asked about discharge on every assessment, only comprehensive assessment."<br><br>SS progress note, dated 4/25/18 at 11:45 a.m., indicated "...He reported feeling down and having trouble concentrating...He plans to stay at the facility long term and wishes to discuss discharge on comprehensive assessments only."<br><br>The clinical record lacked any further documentation related to social service progress notes that showed how the resident's interest in being discharged was addressed.<br><br>During an interview, on 5/18/18 at 10:47 a.m., the Administrator indicated Resident 4's family comes in and takes him out, and they want to move him to the west side of town. The resident's family were looking and might have to put him in another nursing home setting. The resident has not voiced anything else to her about leaving the faciliy. They have a lot of residents in the building right now, and she provides them a list of options, senior apartments, for example with how much the rent runs, with the AL's, she makes the referral and they come talk to residents here, which was the same with other nursing facilities. Resident 4 has multiple people who come in to take him out. The family member had not called | | care plans due for quarterly review by the interdisciplinary team, will be audited by the MDS coordinator to ensure a discharge goal is present when appropriate. The audits will be conducted for six months. The administrator will monitor the provision of optometry and dental services as coordinated by the social worker monthly for six months by reviewing the “To be Seen and Follow-up Post Visit Log”. The audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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for a follow up.

2. On 5/14/18 at 2:40 p.m., Resident 13 said he just wants out of here, he wants to go to another facility, and no one had helped him.

Resident 13's record was reviewed on 5/15/18 at 2:52 p.m. Resident 13's diagnoses included, but were not limited to, stroke with right hemiparesis, type 2 diabetes, high blood pressure, chronic pain, mood disorder, aggressive behaviors, and dementia.

An Annual Minimum Data Set (MDS) assessment, dated 5/31/18, indicated Resident 13 was moderately impaired in cognitive skills for daily decision making and had impairment on both sides for range of motion, including hand, wrist, and elbow.

A care plan, with a revised date of 8/21/17, indicated Resident 13 had "...[history] of calling independent living apartments stating he was looking for apartment and that he can fully take care of himself...Resident will be reoriented to current self sufficiency capabilities when calling about independent living apartments....Resident will be allowed to express himself in a positive manner. Staff will reorient resident to current functional capabilities. SW (Social Worker) will assist resident in finding appropriate placement upon residents request to meet his capabilities."

SS progress note, dated 11/20/17 at 7:53 a.m., indicated "...Resident is still insistent that he is able to care for himself independently and safely. This writer along with admin[istrator], have spoken with resident regarding this, and res states "I can". This writer encourages resident to assist with all daily activities that he is able and to work

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| | with staff/therapy to help build more independence in caring for himself...."<br><br>SS progress note, dated 1/31/18 at 1:33 p.m., indicated "This writer received packet from [name of another facility]. This writer completed pre application for resident. Will return to [name of another facility] for consideration."<br><br>SS progress note, dated 3/22/18 at 3:20 p.m., indicated "Care plan reviewed. Resident is still under the impression that he is able to get his own apartment. He will come and ask this writer to call different apartments for him. Will continue to monitor and assist as needed."<br><br>SS progress note, dated 3/23/18 at 6:32 p.m., indicated "This resident was informed today by this writer that the MD will not write orders for him to d/c (discharged) to an apartment. This resident did not say much to this writer except that he was disappointed."<br><br>The clinical record lacked any further documentation related to social service progress notes that showed how the resident's interest in being discharged was addressed.<br><br>During an interview, on 5/18/18 at 10:43 a.m., the Administrator indicated Resident 13 had wanted to go to an independent apartment, and she checked with his physician who said "absolutely not". The resident was not safe to live in an independent apartment. "He would have to have 24 hour care or someone live full time with him. After the physician talks to him, he was down then he will bounce back, it is continuous with him."<br>3. An interview with Resident 30, on 5/15/18 at 11:01 a.m., indicated the resident had not seen a | | | |

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| | dentist since he was admitted to the facility. The resident had upper dentures at one time and would like to get a replacement for them. The resident had a hard time eating without his dentures. The resident had glasses when he was admitted and they came up missing about a week after his admission. The resident had not seen an eye doctor since he had been admitted to the facility. The resident wore glasses all of the time and he was unable to read books and see the clock in his room because his vision was blurry. The resident had requested from staff to see a dentist and eye doctor but had not received either service.<br><br>Review of the clinical record for Resident 30, on 05/16/18 at 11:27 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, depression, end stage renal failure, epilepsy, muscle weakness, anemia, renal dialysis, insomnia, bilateral below the knee amputation, and contractures of muscle multiple sites.<br><br>The Significant Change MDS assessment for Resident 30, dated 4/10/18, indicated the resident was cognitively intact for daily decision making. The resident did not have glasses and his vision was adequate. The resident had no natural teeth and was edentulous. The resident had broken natural teeth. The resident was admitted to the facility on 12/7/17.<br><br>During an interview with the Administrator, on 05/17/18 at 2:01 p.m., she indicated Resident 30 had not been seen by dentist or an eye doctor. The facility was unable to find any documentation that a dental or optometry services were offered to the resident. The Social Service director would of been responsible to offer dental and optometry services. | | | |

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| | During an interview and observation with Resident 30, on 5/17/18 3:15 p.m., he indicated the facility had not offered vision or dental services on admission or since he had been admitted. The resident had worn glasses for the last three years. The resident had partial dentures on the bottom and a full dentures on the top. He would have an easier time eating and talking if he had his dentures. An observation of the resident's mouth indicated he had six teeth on the bottom in the front and no upper dentures or lower partials dentures.<br><br>The current SS policy provided by the Administrator, on 5/18/18 at 10:00 a.m., indicated Social Services were to "assure that medically related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident on an individual basis." The essential job functions included, but were not limited to, participate in regularly scheduled reviews of resident discharge planning and assist in scheduling dental and eye care services when required or desired.<br><br>3.1-34(a) | | | |
| F 0758 SS=D Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and | | | |

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| | (iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§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;<br><br>§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<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as 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.<br><br>§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.<br>Based on record review and observation, the facility failed to provide appropriate diagnosis for | F 0758 | F758<br>The order for Risperdal for resident | 06/20/2018 |

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| | the clinical use of an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medication use. (resident 33).<br><br>Findings include:<br><br>The record review, on 5/17/18 at 1:31 p.m., for Resident 33's diagnoses included, but were not limited to, vascular dementia, dysphagia, oropharyngeal phase, unspecified abnormalities of gait and mobility, unspecified lack of coordination, cognitive communication deficit, other abnormalities of gait and mobility, essential hypertension, and extra pyramidal and movement disorder.<br><br>The Physician's orders, dated 5/1/18 through 5/31/18, indicated the resident was prescribed Risperdal (anti-psychotic) 0.5 mg (milligram) every am, and Risperdal 1 mg at 2:00 p.m., with a start date of 4/26/18, and diagnoses of delusions/hallucinations.<br><br>Review of the progress note for Resident 33, dated 4/3/18, indicated the resident was "...Confused, judgement/insight: impaired..."<br><br>Review of the progress note for Resident 33, dated 4/26/18, indicated the resident was "...Confused, judgement/insight: impaired. Appropriate mood and affect...."<br><br>The "Social Service Note", dated 11/25/17 at 4:13 p.m., indicated the "resident was involved in resident to resident altercation. This writer witnessed resident and another resident hitting at each other. Administrator notified. Resident was removed from the situation, nurse completed assessment, placed on 1:1 [one to one], guardian/md notified. This writer spoke with | | #33 was clarified by the physician.<br><br>All residents with an order for an anti-psychotic medication and their diagnoses were reviewed by the physician for necessity and clarified as needed.<br><br>The consulting pharmacist will review the anti-psychotic medication regimen for each resident every thirty days with recommendation to the physician when appropriate. Recommendations will be reviewed by the physician and the disposition of the recommendation will be documented and signed by the physician. The DON is responsible maintaining the record of pharmacist/physician recommendations and dispositions.<br><br>The director of nursing will monitor compliance with physician orders for antipsychotic medication and the necessity of use and accompanying diagnoses by reviewing pharmacist/physician recommendations monthly and physician orders daily for six months and ongoing. Results will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | resident about incident and resident did not say anything about it..."<br><br>Review of Hospice "Clinical Notes", dated 4/23/18 at 8:48 p.m., indicated Resident 33 had a hospice diagnosis of Senile degeneration of brain. "Per staff, patient has increased restlessness/anxiety in the afternoon and they are requesting a med change....spoke to [MD] ...he recommended increase in Risperidone instead. Gave verbal order to increase evening dose of Risperidone to 1 mg and administer at 2:00 p.m., rather than 9:00 p.m...."<br><br>On 5/21/18 at 2:56 p.m., the Director of Nursing provided a document titled, "Psychotropic Management". The document indicated "...This Black Box Warning is applicable to all antipsychotics, both atypical (second generation antipsychotics) and typical antipsychotics (first generation antipsychotics)... Atypical antipsychotics are not approved for control of behavior disorders in elderly patients with dementia..."<br><br>3.1-48(b)(1) | | | |
| F 0791<br>SS=D<br>Bldg. 00 | 483.55(b)(1)-(5)<br>Routine/Emergency Dental Srvcs in NFs<br>§483.55 Dental Services<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(b) Nursing Facilities.<br>The facility-<br><br>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br>(i) Routine dental services (to the extent | | | |

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| | covered under the State plan); and<br>(ii) Emergency dental services;<br><br>§483.55(b)(2) Must, if necessary or if requested, assist the resident-<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services locations;<br><br>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;<br><br>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and<br><br>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. | | | |
| | Based on interview and record review, the facility failed to provide follow up dental care for a resident who was referred for root extractions. This affected 1 of 4 residents reviewed for dental care. (Resident 4)<br><br>Findings include: | F 0791 | F791<br>Resident #4 was seen by an outside dentist practitioner.<br><br>All residents were assessed for the need for pending dental work and one resident, who was previously scheduled, was seen | 06/20/2018 |

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| | During an interview, on 5/14/18 at 2:50 p.m., Resident 4 indicated his lower teeth hurt on both sides. He had seen a dentist in the facility but doesn't remember what the dentist said.<br><br>Resident 4's record was reviewed on 5/17/18 at 2:54 p.m. The record indicated Resident 4 had diagnoses that included, but were not limited to, seizures, type 2 diabetes, and mood disorder.<br><br>The Physician's order for Resident 4, dated 5/1/18 through 5/31/18, indicated that he could be seen by a podiatrist, dentist, optometrist, or audiologist as needed.<br><br>The quarterly Minimum Data Set (MDS) assessment, dated 4/26/18, indicated Resident 4 had severe impairment in cognitive skills for daily decision making and had no dental problems.<br><br>A care plan for Resident 4, dated 5/21/18, indicated the "Resident has remaining roots that need extracted from dds(dentist)....Roots will be extracted by dds without s/s(signs/symptoms) of infections thru next review....F/U(follow up) with dds for removing roots...Observe for decreased meal intake, and s/s of pain report findings to nurse and M.D..."<br><br>A dental exam note, dated 12/15/17, for Resident 4 indicated on the 12-15-17 follow up referral "...Pt (patient) has not been out referral rewritten...."<br><br>A dental exam note, dated 4/9/18, for Resident 4 indicated the follow up exam was done today, resident "did not go out to dds for extraction of remaining roots...."<br><br>During an interveiw, on 5/21/18 at 9:54 a.m., the Director of Nursing indicated they checked the | | by an outside dental practitioner as appointed.<br><br>A “To be Seen and Follow-up Post Visit Log” has been initiated to track residents who need to be seen initially and those that need to be seen for follow-up post initial visit by contracted ancillary practitioners or outside practitioners. Nursing staff were inserviced on 6-8-18 regarding ancillary provider services and the referral process, including services needed by outside practitioners on a more urgent time-bases. Families and residents are informed upon admission regarding ancillary practitioner services contracted by the facility.<br><br>The administrator will monitor the provision of dental services as coordinated by the social worker monthly for six months by reviewing the “To be Seen and Follow-up Post Visit Log”. The audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | resident's chart, and they can not find the original referral that was written by the dentist. The only notes were the dental exam.<br><br>The current policy and procedure for "Dental Services" was provided by the Administrator on 5/21/18 at 3:28 p.m. The policy indicated "...Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care...Oral health services are available to meet the resident's needs..Routine and emergency dental services are provided to our residents through:...A contract agreement with a local dentist;...Referral to the resident's personal dentist;...Referral to community dentists; or ...Referral to other health care organizations that provide Dental Services...A complete record of the resident's dental care and services are maintained in accordance with current regulations...personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary."<br><br>3.1-24(a)<br>3.1-24(b) | | | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or | | | |

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| LAWRENCE MANOR HEALTHCARE CENTER | 8935 E 46TH ST<br>INDIANAPOLIS, IN 46226 |

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| | regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation and interview, the facility failed to ensure staff covered their hair completely while in the kitchen and the ceiling was clean over a food preparation area for 2 of 6 observations. This had the potential to affect 35 of 35 residents who consumed food from the kitchen.<br><br>Findings include:<br><br>During the initial dietary inspection, on 5/14/18 at 10:18 a.m., the Dietary Manager and Dietary Aid 1 were observed wearing hair bonnets that did not cover their hair completely. Hair was loose from the bonnet in front of their ears and the back of their necks. Above the stainless steel table in the food prep area were multiple dark gray formations of dust. Between the reach in refrigerator and the stainless steel counter, multiple brown splatters were observed.<br><br>On 5/16/18 at 11:44 a.m., the Dietary Manager and Dietary Aid 1 wore hair bonnets and had hair loose from the bonnet in front of their ears and the nape of their necks.<br><br>On 5/16/18 at 12:13 p.m., Housekeeper 2 entered the kitchen to refill the soap dispenser and did not | F 0812 | F812<br>It is the practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Kitchen employees placed a new hairnet covering the entire head immediately. The dust observed on the ceiling was removed and the area freshly painted on 5-24-18.<br><br>All residents have the potential to be affected. The hairnet policy was reviewed and dietary staff were educated on the policy individually. The ceiling was added to the weekly cleaning schedule effective 5-24-18.<br><br>Dietary staff was inserviced on the amended cleaning schedule and documentation; and use of hairnets on 6-12-18. An audit form was created and will be used to monitor compliance. | 06/20/2018 |

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| | wear a hair bonnet. He stood by the hand washing sink between the stainless steel prep table and the dishwasher for three minutes then left the kitchen. He returned to the kitchen at 12:21 p.m. with the Maintenance Director who assisted him to refill the soap dispenser. The Maintenance Director and Housekeeper 1 had worn hair nets at that time.<br><br>On 5/16/18 at 2:04 p.m., the Dietary Manager indicated the brown splatters had been there since February, and the gray dust comes off the fans circulating the air. The fans were observed attached to the ceiling vents. She did not see the Housekeeper who came into dietary with no hair cover and hair was supposed to be covered in the kitchen.<br><br>A current policy and procedure for "Hair Restraints" was provided by the Administrator on 5/21/18 at 10:37 a.m. The policy indicated "Hair restraints shall be worn by all dietary employees while working in the kitchen area...All employees will provided with a hair restraint. It will be worn by all employees while on duty...Failure to wear appropriate hair restraints shall result in disciplinary action...<br><br>3.1-2(i)(3) | | The food service supervisor or designee will monitor compliance using the audit form daily for eight weeks and weekly for six months. The audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0842 SS=D Bldg. 00 | 483.20(f)(5); 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility | | | |

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| | itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for- | | | |

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| | (i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>Based on interview and record review, the facility failed to have a completed inventory sheet for 2 of 2 residents reviewed for personal property (Resident 24 and Resident 30).<br><br>1.) An interview with Resident 24, on 5/16/18 at 9:56 a.m., indicated the resident's cell phone had been missing for three to four months. The resident reported it to a nurse and they were suppose to get him a new cell phone, but the facility had not replaced it yet.<br><br>Review of the record for Resident 24, on 5/16/18 09:56 a.m., indicated the resident's diagnoses included, but were not limited to, heart failure, atrial fibrillation, shortness of breath, congestive heart failure, major depression disorder, chronic kidney disease, hypertension, dysphagia, and diabetes. | F 0842 | F842<br>Inventory sheets were completed for residents #24 and #30.<br><br>The medical records for all residents were audited for the presence of an inventory sheet and any found to be deficient were corrected.<br><br>Residents and resident representatives are provided an inventory sheet at the time of admission and are assisted if needed with completing the form and/or identifying belongings. Residents and resident representatives are encouraged to keep the inventory sheets current when new belongings are | 06/20/2018 |

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| | The Annual Minimum Data (MDS) assessment for Resident 24, dated 3/26/18, indicated the resident was moderately impaired for daily decision making and it was somewhat important to take care of his belongings.<br><br>During an interview with the Director Of Nursing (DON), on 5/18/18 at 9:55 a.m., she indicated Resident 24 did not have an inventory sheet completed.<br><br>An interview with the Administrator, on 5/21/18 at 11:17 a.m., indicated she had not had a report of Resident 24's cell phone missing.<br><br>2.) An interview with Resident 30, on 5/15/18 at 11:05 a.m., indicated the resident's glasses had come up missing after he was admitted to the facility.<br><br>Review of the record for Resident 30, on 05/16/18 at 11:27 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, depression, end stage renal failure, epilepsy, muscle weakness, anemia, renal dialysis, insomnia, bilateral below the knee amputation, and contractures of muscle multiple sites.<br><br>The progress note for Resident 30, dated 12/8/17 at 8:48 a.m., indicated the resident was admitted on 12/7/18 and had a large amount of personal items that were brought from the other facility.<br><br>The Significant Change MDS assessment for Resident 30, dated 4/10/18, indicated the resident was cognitively intact for daily decision making and it was very important to take care of his personal belongings.<br><br>During an interview with the Director Of Nursing | | introduced or removed. Staff will aid as needed. Residents will be reminded of the use of inventory sheets at Residents' Council meeting. The admissions person will ensure an inventory sheet is available upon admission and completed. The medical records person was inserviced 6-11-18 regarding the inventory sheet and retention.<br><br>The medical records person will audit open charts quarterly or more often as needed when open records are being thinned to ensure the inventory sheet remains a permanent part of the record. The audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | (DON), on 5/18/18 at 9:55 a.m., she indicated Resident 30 did not have an inventory sheet completed.<br><br>An interview with the Administrator, on 5/21/18 at 11:17 a.m., indicated she was not aware of Resident 30's glasses missing.<br><br>The personal property policy provided by the Administrator, on 5/18/18 at 1:18 p.m., indicated "The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished."<br><br>3.1-50(a) | | | |
| F 0924 SS=D Bldg. 00 | 483.90(i)(3)<br>Corridors have Firmly Secured Handrails<br>§483.90(i)(3) Equip corridors with firmly secured handrails on each side.<br>Based on observation and interview, the facility failed to provide hand rails in the hallway on the west side of the building for 1 of 4 halls observed for hand rails.<br><br>Findings include:<br><br>During an observation of the facility environment with the Maintenance Supervisor, on 5/21/18 at 10:24 a.m., no hand rails were attached to the walls on the west side of the building.<br><br>An interview, on 5/21/18 at 10:24 a.m., with the Maintenance Supervisor indicated he did not know why there had been no hand rails on the west side of the building..<br><br>3.1-19(f)(3) | F 0924 | F924<br>Upon discovery, an outside contractor was contacted to prepare installation of handrails where missing. For residents immediately affected, the missing handrail has not compromised resident mobility or safety.<br><br>Upon discovery, an outside contractor was contacted to prepare installation of handrails where missing. For residents potentially affected, the missing handrail has not compromised resident mobility or safety.<br><br>Measurements and specifications have been taken and materials ordered. Labor has been | 06/20/2018 |

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| | | | committed to the project and Installation will commence immediately upon the arrival of the materials. Maintenance person inserviced on 6-1-18 regarding visual inspection of handrails for preventative maintenance, adjustment, or repair.<br><br>Handrail inspection has been added to preventative maintenance log and maintenance will inspect weekly for four weeks and monthly for six months and ongoing. Log will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL<br>A physical examination shall be required for each employee of a facility within (1) month prior to employment.<br><br>This rule is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to have employee physicals completed for 4 of 10 employee records reviewed. (Minimum Data Set Coordinator, CNA 4, Dietary Service Manager and LPN 3)<br><br>Findings include: | F 9999 | F9999<br>The four employees identified during survey as lacking an employee physical have all received the required health screening and are in compliance.<br><br>All current employee files were audited for completion of the physical/health screening to ensure compliance.<br><br>The health screening forms used upon hire and annually were updated and given to the HR/Office | 06/20/2018 |

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| | A review of the employee records provided by the Regional Business Office Manager, on 5/14/18 at 2:24 p.m., indicated the Minimum Data Set (MDS) Coordinator was hired on 1/11/2018 and did not have a physical completed, CNA (Certified Nurse Aide) 4 was hired on 2/19/18 and did not have a physical completed, the Dietary Service Manager was hired on 2/26/18 and did not have a physical completed and LPN (Licensed Practical Nurse) 3 was hired on 4/6/18 and did not have a physical completed.<br><br>An interview with the Regional Business Office Manager, on 5/21/18 at 2:48 p.m., she indicated the MDS Coordinator, CNA 4, the Dietary Service Manager, and LPN 3 had not had pre employment physicals completed.<br><br>The current employment health requirement policy provided by the Administrator, on 5/21/18 at 3:11 p.m., indicated the health review was required to be completed after the employee had accepted the job and preferable prior to the first day of work. The Director Of Nursing or RN designee would conduct the health review. | | Manager and she was inserviced regarding their use on 6-4-18.<br><br>The office manager will conduct an employee file audit to ensure employee health screenings upon hire and annual health updates (PPD Mantoux) are present and timely, weekly for two months and monthly for six months. The audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |