STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	08/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00236738. Complaint IN00236738- Federal/State deficiencies related to the allegations are cited at F164, F225, F226, F309, F323, and F328. Unrelated deficiencies are cited at F356 and F465. Survey dates: August 13 and 14, 2017 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Census bed type: SNF/NF: 35 Total: 35 Census payor type: Medicare: 1 Medicaid: 27 Other: 7 Total: 35 These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on August 17,	F 0000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	

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

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	2017.			
F 0164 SS=D Bldg. 00	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in			

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	compliance with 45 CFR 164.506; (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. Based on observation, interview and record review, the facility failed to maintain a resident's privacy while providing peri care for 1 of 1 residents reviewed for personal care (Resident C). Finding includes: The facility tour began on 8/13/17 at 5:20 p.m., with the Director of Nursing in attendance and the following were observed: On 8/13/17 at 6:10 p.m., the Director of Nursing (DON) indicated Resident C was incontinent of his bowel and bladder and he was totally dependent for his ADL (Activities of Daily Living) care. On 8/13/17 at 6:20 p.m., CNA 1 and CNA 2 was observed providing incontinence care for Resident C. While incontinence care was being performed, Resident C was left uncovered	F 0164	**F164 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Nurse Aides # 360981 & 358966 have been re-educated on Resident Rights (Focus- Dignity & Privacy) on 8/13/17. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents potentially could be affected by deficient practice. Nursing Staff will be educated on Resident Right (Focus-Dignity & Privacy During Care) ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Nursing Staff will be educated on Resident Right (Focus-Dignity & Privacy During Care) ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Director of Nursing or designee will complete audits on 8 residents 2X weekly X 4 weeks then weekly X 4 weeks then	09/12/2017

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	throughout the entire personal care. The privacy curtain was partially pulled to the end of his bed and the door to the hallway was left open during the incontinence care. During an interview on 8/13/16 at 6:35 p.m., CNA 1 indicated she should have closed the hallway door while giving incontinence, but he had an independent person who lived in the room with him who came in and out of the room and she did not want to close the door on him. She indicated they should have closed the privacy curtain while giving the incontinence care and she did not cover him up during the personal care because he was constantly moving his legs and he would not leave the blankets on his legs. A document titled "Job Description/Performance Evaluation" dated 4/25/17, provided by the Payroll Manager on 8/14/17 at 2:00 p.m., indicated "...Key/Essential Duties: Patient/Resident Care:..General Care:.. Maintains privacy and dignity while providing care and services...." CNA 1 signed her name to this document dated 4/25/17 under the areas titled "Job description Acknowledgment" and "Performance Evaluation Acknowledgement."		monthly X 3 months to ensure residents are being provided with privacy and dignity during personal care. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	A document titled "New Hire Clinical Orientation Standards-CNA Phase II" dated 4/29/17, provided by the Payroll Manager on 8/14/17 at 2:00 p.m., indicated "Clinical Orientation Phase II/Practices and Procedures: Record the date employee was able to demonstrate or verbalize correct understanding of practice in accordance with facility policies and procedures...." CNA 1 signed her name to this document dated 4/29/17. The record review for Resident C was completed on 8/14/17 at 4:45 p.m. Diagnoses included, but were not limited to, profound intellectual disabilities, cerebral palsy, encounter for attention to Gastrostomy and dysphagia. The resident had a Care Plan dated 2/27/15 with a revised date 4/22/17, which addressed the problem the resident was dependent for all ADL's due to diagnoses of cerebral palsy and developmental disability. Interventions/Tasks included, but were not limited to, "...." A current policy titled "Residents' Rights" dated 6/98 with a revision date 6/15, provided by the Director of Nursing on 8/14/17 at 12:55 p.m., contained the following, "Policy: It is the policy of			

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	[Name of Company] and its subsidiaries to provide our residents with a comfortable, private and safe environment in which to live. Purpose: To establish, administer and enforce the rights of our residents. Scope: This policy applies to all employees. Terms: A. Each resident must be treated with respect...Employees are expected to protect the rights of each resident at all times. B. Each resident is entitled to their privacy... D. [Name of Company] expects every resident to be treated with consideration and full recognition of dignity and individuality, including privacy in treatment and care of personal needs. E. Any infringement of the comfort, privacy and personal safety of a resident will result in disciplinary action up to and including termination...." This Federal tag relates to Complaint IN00236738. . 3.1-3(p)(4)			
F 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-			

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	(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and			

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	to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to follow their policy and procedure related to investigating an abuse allegation for 1 of 3 residents reviewed for abuse allegations (Resident H) Finding includes: A document titled "Verification of Incident Investigation /Administration Summary" dated 6/15/17, indicated Resident H was being transferred by CNA 6 using a stand up lift and she slipped from the lift and was lowered to the floor by the CNA. An abuse	F 0225	**F225 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Education will be completed with the leadership team regarding proper investigation of abuse allegations ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents are potentially affected by this deficient practice. Executive Director or designee will	09/12/2017

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	allegation was made indicating CNA 6 was rough with the resident during the transfer. Resident H made another abuse allegation against CNA 6 indicating he was physically abusive to her and hit her in the back. . Staff interviews were completed by the Director of Nursing (DON). A resident interview was completed using the MDS (Minimum Data Set) assessment dated 6/11/17. During the investigation the allegation Resident H made regarding being hit in the back was determined to be the same incident as the incident, which occurred on 6/10/17 with the transfer utilizing the stand up lift on 6/10/17. The physical abuse allegation was unsubstantiated against CNA 6, but he was terminated related to an improper use of a mechanical lift while transferring a resident. The report lacked documentation of any other residents being interviewed for possible abuse. During an interview on 8/14/17 at 6:40 p.m., the DON indicated there were no other residents interviewed during this abuse allegation investigation for possible abuse.		complete Incident Investigation Education (Focus-Allegations of Abuse) with leadership team. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** All investigations of allegations of abuse will follow center policies and procedures. Center will include interviews with residents not involved in reported incident to ensure an occurrence isn't wide spread. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** ED or designee will complete audits with each reportable incident 2X weekly X 4 weeks then weekly X 4 weeks then monthly X 3 months to ensure the investigation process is being followed. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	A current policy titled "Abuse Prevention, Intervention, Investigation & Crime Reporting Policy" revision date November 2016, provided by the Interim Executive Director on 8/14/17 at 2:00 p.m., contained the following, "...Policy:..In response to allegations of abuse, neglect, exploitation or mistreatment, the facility will:..Have evidence that all alleged violations are thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress....Procedures:..6. Investigation:..At the direction of legal counsel in anticipation of litigation, individuals with direct knowledge of abuse should be interviewed. Interviews may be documented on an Interview Record and are considered Attorney Client Privileged, Attorney Work Product, Patient Safety Work Product and confidential. Written statements should never be taken or requested unless directed to do so by legal counsel. The facility will complete a Verification of Incident Investigation giving a brief description of the allegation, thorough summary of findings including information obtained in interviews, follow-up actions taken and notifications made. This verification may be provided			

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	to federal or state survey agencies upon request...." This Federal tag relates to Complaint IN00236738. . 3.1-28(d)			
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their			

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	staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on interview and record review, the facility failed to follow their Abuse Prevention policy/procedures, related to educating residents and staff regarding what constitutes abuse and the appropriate personnel to inform regarding abuse allegations for 2 of 6 employees and 1 of 5 residents reviewed for the facility following their abuse policy and procedures (Housekeeper 7, Laundry Staff Member 8 and Resident H). Findings include: While completing the Abuse Prohibition Protocol the following occurred: 1. During an interview on 8/14/17 at 1:03 p.m., Housekeeper 7 indicated she did not know the different types of abuse because she had only worked at the facility for a short time. She indicated there are papers listed on the board she was to look, but she had not done that	F 0226	**F226 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Center staff will be re-educated on abuse policies and procedures: Signs of Abuse, Reporting Guidelines, types of Abuse. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents are potentially affected by this deficient practice. Center staff will be re-educated on abuse policies and procedures: Signs of Abuse, Reporting Guidelines, types of Abuse. A reportable incident example sheet will be provided to all employees to be placed with their name badge as a visual Q of the policy.	09/12/2017

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	yet, but she would have to go familiarize herself with those papers. She remembered watching a video during orientation and that may have also had the types of abuse on it, but she did not remember for sure. 2. During an interview on 8/14/17 at 1:06 p.m., Laundry staff member 8 indicated she knew that physical and substance abuse were two types of abuse, but she could not remember the other types of abuse. She had only worked at the facility for a short period of time. She watched a video in orientation, which discussed abuse and she was supposed to learn the types of abuse off the video. She indicated the Payroll Manager and the Housekeeping/Laundry Supervisor was in and out during setting up for a resident event they were having during the time they were watching the abuse video, so she did not get taught the types of abuse. She indicated she would have to go back to the board with the papers on it and look at the different types of abuse. She indicated she guessed they were supposed to learn about abuse from the video. 3. During an interview on 8/14/17 at 1:20 p.m., Resident H indicated he had not been abused or seen abuse since he was admitted a short time ago. He was		During admission IDT meetings center residents will be provided with verbal and written education regarding Residents' Rights. This will be ongoing. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Center staff will be re-educated on abuse policies and procedures: Signs of Abuse, Reporting Guidelines, types of Abuse. During admission IDT meetings the resident will be provided with verbal and written education regarding residents' rights and abuse. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** ED or designee will complete audits 2X a week with 5 staff members X 4 weeks then weekly X 4 weeks then monthly X 3 months to ensure facility staff are aware of types/signs of abuse and with whom to report. SSD or designee will complete audits with 5 residents 2X weekly X 4 weeks then weekly X 4 weeks then monthly X 3 months to ensure residents are aware of with whom to report allegations Audit findings will be presented to	

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	not told who he should report an abuse allegation to if he needed to and he did not know anyone here at the facility yet to know who to report something like that to. A current policy titled "Abuse Prevention, Intervention, Investigation & Crime Reporting Policy" revision date November 2016, provided by the Interim Executive Director on 8/14/17 at 2:00 p.m., contained the following, "...Policy:..In response to allegations of abuse, neglect, exploitation or mistreatment, the facility will:..Procedures:..2. Training: Upon hire, annually , and additionally if determined appropriate, employee's will be provided training on the following topics: Facility Abuse Prevention, Intervention, Investigation and Crime Reporting policy, including their reporting responsibilities...What constitutes abuse, neglect, involuntary seclusion, and misappropriation of resident property, mistreatment, and an injury of unknown source...5. Identification: Residents, resident representatives, families and staff shall be informed that they may report any concerns, incidents or grievances without fear of reprisal or retribution. All persons making such reports are to be provided a non-threatening environment and		the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	anonymity (if desired) to express identified concerns, with feedback regarding the concerns expressed. Upon hire and at least annually, all employees will be trained on recognizing and identifying actual or suspected occurrences of abuse, neglect, misappropriation of resident property, and mistreatment...." This Federal tag relates to Complaint IN00236738. 3.1-28			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's			

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	155298	A. BUILDING 00 B. WING	08/14/2017

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	comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, interview and record review, the facility failed to ensure accurate skin condition assessments were completed for 1 of 1 resident reviewed for non-pressure skin conditions (Resident B) Finding includes: During the facility tour on 8/13/17 at 5:55 p.m., with the Director of Nursing	F 0309	**F309 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Education will be completed with Nursing Staff regarding proper assessment and documentation of non-pressure skin impairments. . ***Plan / Process to identify other***	09/12/2017

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	(DON) in attendance. The DON indicated Resident B was totally dependent on staff for ADL (Activities of Daily Living) assistance. She indicated the resident had an accidental incident, which occurred on 7/29/17, which caused a "Minor Injury" to the left frontal area of her head. CNA 4 pulled the resident up in bed by herself when her care plan indicated she was a two person assist and she hit the resident's head on the headboard of the bed. She indicated in order for the left frontal part of her head to hit the headboard of the bed with the bed flat, CNA 4 "probably hyperextended" her head when she pulled her up in the bed by pulling her up fast and with some "strength." She indicated the CNA was a "big gal" and she would be able to pull her up in the bed by herself if she was on the side of the bed with a hand on each side of the resident and pulled her upwards towards the headboard. She indicated the resident's family member "insisted" she be sent out to the hospital to be evaluated on 8/2/17 and then again on 8/9/17, because she did not feel she was getting any better. Neurochecks were completed, but they were not done every 15 minutes as the policy required because she did not think the nurse understood how to open the neurocheck event because there were several of them opened, so they were		***residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents with non pressure skin conditions are potentially affected by this deficient practice. Residents with non pressure skin conditions were reviewed and care plans updated as need. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Education will be completed with Nursing Staff regarding proper assessment and documentation of non-pressure skin impairments. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will complete audits on 5 residents wound assessments 2X weekly X 4 weeks then weekly X 4 weeks then monthly X 3 months to ensure accurate assessment and documentation of non-pressure skin impairments. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	done every eight hours. She indicated by Resident B hitting her head she should have had the neurochecks done according to their policy starting out every 15 minutes. She indicated when the resident went to the hospital on 8/2/17, the hematoma was not there according to the Cat Scan results. On 8/9/17, was when the hematoma was observed on the Cat Scan. The resident was observed at that time to have a golf ball sized shaped hard knot in the left to center of her frontal part of her head and a scabbed area the size of a dime with matted hair around it on the left side of her frontal part of her head. During a confidential interview on 8/13/17 at 4:57 p.m., the person indicated CNA 4 lifted the resident by herself and hit her head on the headboard. She had 60 to 90 milliliters of blood, which bled from her head. There was no swelling initially when the incident occurred. Approximately three days after the incident, Resident B's family member wanted her sent to the hospital to be evaluated, which was on 8/2/17. The resident had a hematoma. She indicated the scabbed area was where she had the bleeding and there was a previous scab there and CNA 4 knocked that scab off when she hit her head. She notified the			

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	DON regarding the incident and she was told by the DON to start neurochecks, but she only had to do them every eight hours because the resident did not have a fall. She indicated she clarified with the DON about the neurochecks because the resident had a head injury and she was told if it was not a fall she only had to put them in the computer for every eight hours. A document titled "Disciplinary Action Notice" dated 8/9/17, provided by Payroll Manager on 8/14/17 at 2:00 p.m., indicated on 7/29/17 on 2nd shift CNA 4 "Policy Violated:...Substandard of care leading to an accidental resident injury. Detailed Description of Incident...[Name of Employee] was attempting to move a resident up in bed independently and that resident's head hit the head board causing a hematoma and abrasion. Summary of disciplinary action to be taken...Final Written Warning-Follow up in 30 days with DON. Consequences of failure to abide by policy: Disciplinary action up to and including termination." Signed by CNA 4. During an interview on 8/14/17 at 2:12 p.m., CNA 4 indicated on 7/29/17 after 10 p.m., and it was her last bed check and she was trying to get finished and Resident B was down in the bed. She			

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	was not wet, so CNA 4 thought instead of bothering the other CNA's who were doing their bed checks and she was not wet, she would just pull her up by herself. She lowered the head of the bed, placed her back to the resident, placed a hand on each side of the resident ton the draw sheet under her and pulled the drawsheet and the resident up towards the headboard fast. She heard a "thud" and went to look at the resident's head and seen it was bleeding. She ran to get the nurse. She indicated the resident's head was always turned towards the left, so that is how she thought she hit the front part of her head on the headboard. She indicated the nurse told her she knocked the scab off an old sore. She indicated she was supposed to have two assists to do care for her, but she wanted to get her done, since she was not wet. She indicated she regretted doing it by herself now. She indicated she did not do it by herself because there was not enough staff. Resident B's record was reviewed on 8/14/17 at 3:30 p.m. Diagnoses included, but were not limited to, Type 2 Diabetes Mellitus, seizures, dysphagia, multiple contractures, and persistent vegetative state. A progress note dated 7/29/17 at 11:31			

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	p.m., indicated "Resident post scalp on top of front left side of head, lessened and part came off when CNA [Name of CNA] pulled resident up toward the head of the bed causing the resident head to hit the head board, small amount of bleeding noted approximately 90 cc [cubic centimeters]...." The resident's record lacked assessments for the hematoma to her forehead. A CT of the Brain/Head from [Name of Hospital] dated 8/2/17, indicated left frontal scalp hematoma noted. A CT of the Brain/Head from [Name of Hospital] dated 8/9/17, indicated there is a large scalp hematoma along the external convexity of the left fontal bone. During an interview on 8/14/17 at 6:50 p.m., the DON indicated there was no assessments of the hematoma completed, just the scab for Resident B. She indicated she can "just tell" if the hematoma was getting any better or worse, without an assessment. A current policy titled "Skin Integrity" revised date December 2016, provided by the DON on 8/14/17 at 7:50 p.m., contained the following, "...Procedure:..15. If skin integrity issues			

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	are identified post-admission to the facility the following documented information is required: Wound Specifics: Location of wound-as specifically as possible, Size of the wound including length, width, and depth in centimeters... Amount of drainage using terms of light, moderate or heavy, Description of the wound bed:..Notation on the 24 hour report indicating the skin condition...16. Skin integrity change of condition noted on the 24-hour report to be reviewed at daily stand up meeting. Resident may be added by IDT [Interdisciplinary] Walking Rounds for Identification of necessary interventions...18. DON/Designee completes weekly random skin assessments...." This Federal tag relates to Complaint IN00236738. . 3.1-37(a)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -			

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	(1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview and record review, the facility failed to ensure safe bed mobility (Resident B) and transfer method (Resident H) was provided to prevent an accidental incident and falls for 2 of 4 residents reviewed for accidents Findings include:	F 0323	**F323 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Education will be completed with nursing staff regarding proper bed mobility and transfer techniques. ***Plan / Process to identify other residents potentially affected by the same deficient practice and***	09/12/2017

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	1. During the facility tour on 8/13/17 at 5:55 p.m., with the Director of Nursing (DON) in attendance. The DON indicated Resident B was totally dependent on staff for ADL (Activities of Daily Living) assistance. She indicated the resident had an accidental incident, which occurred on 7/29/17, which caused a "Minor Injury" to the left frontal area of her head. CNA 4 pulled the resident up in bed by herself when her care plan indicated she was a two person assist and she hit the resident's head on the headboard of the bed. She indicated in order for the left frontal part of her head to hit the headboard of the bed with the bed flat, CNA 4 "probably hyperextended" her head when she pulled her up in the bed by pulling her up fast and with some "strength." She indicated the CNA was a "big gal" and she would be able to pull her up in the bed by herself if she was on the side of the bed with a hand on each side of the resident and pulled her upwards towards the headboard. She indicated the resident's family member "insisted" she be sent out to the hospital to be evaluated on 8/2/17 and then again on 8/9/17, because she did not feel she was getting any better. The resident was observed at that time to have a golf ball sized shaped hard knot in the left to center of her frontal part of her		***corrective action(s) to be taken;*** Center residents that are dependent with bed mobility and transfers have the potential to be affected by this deficient practice. Center Dependent Residents bed mobility and transfer status have been reviewed & care plans corrected as needed. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Education will be completed with nursing staff regarding proper bed mobility and transfer techniques. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will complete audits on 5 resident's 2Xs weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months to ensure proper technique are used with bed mobility and transfers. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	head and a scabbed area the size of a dime with matted hair around it on the left side of her frontal part of her head. During a confidential interview on 8/13/17 at 4:57 p.m., the person indicated CNA 4 lifted the resident by herself and hit her head on the headboard. She had 60 to 90 milliliters of blood, which bled from her head. There was no swelling initially when the incident occurred. Approximately three days after the incident, Resident B's family member wanted her sent to the hospital to be evaluated, on 8/2/17. The resident had a hematoma. During an interview on 8/14/17 at 1:25 p.m., the Social Service Director (SSD) indicated she was working the next day after the incident of her head getting hit into the headboard and the family member asked her to come with her to the resident's room and she went with her. She indicated Resident B had a square bandage on her left side of her forehead and there was a scant amount of blood on her forehead. The resident's family member indicated to her at that time she wanted two staff members to take care of the resident at all times. During an interview on 8/14/17 at 2:12 p.m., CNA 4 indicated on 7/29/17 after			

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	10 p.m., and it was her last bed check and she was trying to get finished and Resident B was down in the bed. She was not wet, so CNA 4 thought instead of bothering the other CNA's who were doing their bed checks and she was not wet, she would just pull her up by herself. She lowered the head of the bed, placed her back to the resident, placed a hand on each side of the resident ton the draw sheet under her and pulled the drawsheet and the resident up towards the headboard fast. She heard a "thud" and went to look at the resident's head and seen it was bleeding. She ran to get the nurse. She indicated the resident's head was always turned towards the left, so that is how she thought she hit the front part of her head on the headboard. She indicated the nurse told her she knocked the scab off an old sore. She indicated she was supposed to have two assists to do care for her, but she wanted to get her done, since she was not wet. She indicated she regretted doing it by herself now. She indicated she did not do it by herself because there was not enough staff. Resident B's record was reviewed on 8/14/17 at 3:30 p.m. Diagnoses included, but were not limited to, Type 2 Diabetes Mellitus, seizures, dysphagia, multiple contractures, and persistent vegetative			

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	state. The resident had a Care Plan dated 6/10/16 revised on 11/29/16, which addressed the problem she required total assistance with ADL's. Interventions/Tasks included, but were not limited to, "...6/10/16--Bed Mobility-Two person physical assistance required, Maintain proper body alignment...." A progress note dated 7/29/17 at 10:52 p.m., indicated "F/U [follow/up] incident: CNA was canceled, RE: [regarding] writer informed CNA to place a pillow in between the head board and resident when moving resident up in bed, and to always use 2 asst [assists] with repositioning resident...." A progress note dated 7/29/17 at 11:31 p.m., indicated "Resident post scalp on top of front left side of head, loosened and part came off when CNA [Name of CNA] pulled resident up toward the head of the bed causing the resident head to hit the head board, small amount of bleeding noted approximately 90 cc [cubic centimeters]...." A document titled "Wound Assessment" undated, indicated the resident had an abrasion to her left forehead, which she			

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	acquired at the facility. Measured 0.7 x 0.7 x 0 cm (centimeters). The area was 100% covered in a scab. A document titled "Wound Assessment" dated 8/7/17, indicated the resident had an abrasion to her left forehead, which she acquired at the facility. Measured 0.7 x 0.7 x 0 cm (centimeters). The area was 100% covered in a scab. A CT of the Brain/Head from [Name of Hospital] dated 8/2/17, indicated left frontal scalp hematoma noted. A CT of the Brain/Head from [Name of Hospital] dated 8/9/17, indicated there is a large scalp hematoma along the external convexity of the left fontal bone. A document titled "Disciplinary Action Notice" dated 8/9/17, provided by Payroll Manager on 8/14/17 at 2:00 p.m., indicated on 7/29/17 on 2nd shift CNA 4 "Policy Violated:...Substandard of care leading to an accidental resident injury. Detailed Description of Incident...[Name of Employee] was attempting to move a resident up in bed independently and that resident's head hit the head board causing a hematoma and abrasion. summary of disciplinary action to be taken...Final Written Warning-Follow up in 30 days with DON. Consequences of failure to			

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	abide by policy: Disciplinary action up to and including termination." Signed by CNA 4. 2. A document titled "Verification of Incident Investigation /Administration Summary" dated 6/15/17, indicated Resident H was being transferred by CNA 6 using a stand up lift and she slipped from the lift and was lowered to the floor by the CNA. A document titled "[Name of Company] Disciplinary Action Notice" dated 6/15/17, indicated CNA 6 was involved in an incident on 6/15/17 on second shift. The incident date was 6/10/17 on second shift. "Policy Violated...Resident was completing a transfer utilizing a mechanical lift without assistance from a 2nd staff member. This transfer ended with resident being lowered to the floor. In addition, allegations were made that resident was physically and verbally abusive to resident. These allegations were unsubstantiated following investigation. Detailed Description of Incident:..CNA attempted to transfer a resident following her back surgery using the stand up lift without assistance. IN addition resident did not provide a barrier between resident's back and the lift pad for the stand up lift. Summary of			

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	disciplinary action to be taken: Resident [sic] was terminated r/t [related/to] inappropriate use of the stand up lift (operating with 1 staff member). Consequences of failure to abide by policy: NA." Signed by CNA 6 on 6/15/17. This Federal tag relates to Complaint IN00236738. . 3.1-45(a)(2)			
F 0328 SS=D Bldg. 00	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the			

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	resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.			
	Based on observation, interview and record review, the facility failed to ensure a feeding tube pump was operated by licensed personnel for 1 of 4 residents reviewed for tube feedings (Resident C).	F 0328	**F328 SS:D :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;***	09/12/2017

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	Finding includes: The facility tour began on 8/13/17 at 5:20 p.m., with the Director of Nursing in attendance and the following were observed: On 8/13/17 at 6:10 p.m., Resident C's white colored tube feeding pump was in use at that time. On 8/13/17 at 6:20 p.m., CNA 1 and CNA 2 was observed providing incontinence care for Resident C. Prior to providing the incontinence care, CNA 1 was observed pushing a button on the Kangaroo pump (type of feeding pump to infuse the feeding), which put the infusion of the feeding on hold. While incontinence care was being performed, Resident C's tube feeding pump was on hold. After the incontinence care was completed, CNA 1 pushed a button on the feeding pump and started the feeding infusing. During an interview on 8/13/17 at 6:35 p.m., CNA 1 indicated the CNA's were allowed to place the tube feedings on hold while they had the head of the bed lowered, then start it back up when they were finished with the resident's care because sometimes the resident's nurse		Education with CNAs# 360981 & 358966 involved at time of deficient practice (8/13/2017) Education will be completed with nursing staff on CNA scope of practice in relation to tube feedings. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents that have a feeding tube have the potential to be affected by this deficient practice. Residents with a feeding tube have been reviewed and care plans updated as needed. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Education will be completed with nursing staff on CNA scope of practice in relation to tube feedings. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will complete audits on all residents with tube feedings to ensure CNAs practice within scope: 2Xs weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months to ensure CNAs are acting within scope of practice in	

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	was not around when they needed to do the personal care. She indicated they could not push any other buttons on the feeding pump except the one to place it on hold and restart it because while they were giving personal care the resident had to lay flat and the feeding could no be infusing during that time. During an interview on 8/13/17 at 6:46 p.m., LPN 3 indicated the CNA's were not allowed to place the feeding pumps on hold or restart them because the residents with tube feedings required 1500 mls of fluids a day between their feedings and water. If the CNA forgot to restart a feeding pump, which was on hold, the resident would not get the appropriate amounts of fluid and nutrition. A document titled "Job Description/Performance Evaluation" dated 4/25/17, provided by the Payroll Manager on 8/14/17 at 2:00 p.m., indicated "...Key/Essential Duties: Patient/Resident Care:.. Recognizes and adheres to capabilities within CNA scope of practice...." CNA 1 signed her name to this document dated 4/25/17 under the areas titled "Job description Acknowledgment" and "Performance Evaluation Acknowledgement."		relation to tube feedings. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	A document titled "New Hire Clinical Orientation Standards-CNA Phase II" dated 4/29/17, provided by the Payroll Manager on 8/14/17 at 2:00 p.m., indicated "Clinical Orientation Phase II/Practices and Procedures: Record the date employee was able to demonstrate or verbalize correct understanding of practice in accordance with facility policies and procedures...Section 4: Specialty Care:..Tube feeding precautions [dated 4/27]...." The record review for Resident C was completed on 8/14/17 at 4:45 p.m. Diagnoses included, but were not limited to, profound intellectual disabilities, cerebral palsy, encounter for attention to Gastrostomy and dysphagia. The resident had a Care Plan dated 2/27/15 with a revised date 4/22/17, which addressed the problem the resident was dependent for all ADL's due to diagnoses of cerebral palsy and developmental disability. Interventions/Tasks included, but were not limited to, "...2/27/17--Dependent for dressing, toileting, transferring and bathing of 1-2 staff... Has G tube-contact nurse prior to manipulating...." A current policy titled "Enteral Feeding Tube, Care of" dated 2006, provided by			

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	the Director of Nursing on 8/14/17 at 12:55 p.m., contained the following, "Basic Responsibility: Licensed Nurse... Enteral Nutritional Therapy, (Tube Feedings)...Basic Responsibility: Licensed Nurse...." This Federal tag relates to Complaints IN00236738. 3.1-47(a)(2)			
F 0356 SS=C Bldg. 00	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law)			

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	(C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure timely posting of the daily nursing staff information for 1 of 2 days observed during the survey. This deficient practice had the potential to impact 35 of 35 residents and visitors. Finding includes: Upon entering the facility on 8/13/17 at 2:55 p.m., the nurse staffing information	F 0356	**F356 SS:C :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Staff posting was corrected on 8/13/2017. ***Plan / Process to identify other residents potentially affected by the same deficient practice and***	09/12/2017

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	posted on the first floor in the plastic sleeve on the wall was dated 8/10/17. Behind that staffing posting was two other postings dated 8/11/17 and 8/12/17. The plastic sleeve lacked a current nursing staffing posting dated 8/13/17. Receptionist 5 provided a copy of those nursing staffing sheets and indicated as far as she knew those were the only ones posted at that time. During an interview on 8/13/17 at 5:20 p.m., the Director of Nursing indicated the nurse staffing information dated 8/10/17, should not have been posted, the nurse staffing information dated 8/13/17, should have been posted. There should have been a nurse staffing posting in the sleeve dated 8/13/17. When informed there was no nurse staffing posting available, she indicated she would get the current one posted.		***corrective action(s) to be taken;*** Center residents and visitors have the potential to be affected by this deficient practice. Education will be completed with leadership team and receptionists regarding daily staff posting. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Education will be completed with leadership team and receptionists regarding daily staff posting. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** ED or designee will complete audits on posting of hours 2Xs weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months to ensure daily staff posting is present and accurate Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	
F 0465 SS=E Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON			

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	(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to ensure tube feeding pumps were kept clean for 4 of 4 residents' equipment observed for adequate sanitation (Residents E, B, F and C). Findings include: The facility tour began on 8/13/17 at 5:20 p.m., with the Director of Nursing (DON) in attendance and the following were observed: 1. At 5:22 p.m., Resident E's white colored tube feeding pump was observed with a dried tan colored liquid, which had ran down onto the metal pole, which the feeding pump was clamped onto, the feeding pump and the metal base with metal legs and wheels had the dried tan colored liquid splattered on them.. The tube feeding pump was not in use at that time. The DON indicated at that time she was supplemental feedings at night.	F 0465	**F465 SS:E :** ***Immediate corrective action(s) for those Residents affected by the deficient practice;*** Feeding pumps were Checked & cleaned per housekeeping on 8/14/2017. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;*** Center residents with feeding tubes have the potential to be affected by this deficient practice. Center will complete education with leadership team & housekeeping staff that poles/pumps are to be cleaned daily. ***Facility measures and systemic changes to ensure the deficient practice does not recur;*** Center will complete education with	09/12/2017

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	On 8/14/17 at 1:00 p.m., Resident E's white colored tube feeding pump had continued to have dried tan colored liquid, which had ran down onto the metal pole, which the feeding pump was clamped onto, the feeding pump and the metal base with metal legs and wheels had the dried tan colored liquid splattered on them. The tube feeding pump was not in use at that time. 2. At 5:55 p.m., Resident B's white colored tube feeding pump had a large amount of dried tan colored liquid, which had ran down onto the metal pole, which the feeding pump was clamped onto, the feeding pump and the metal base with metal legs and wheels had large areas of the tan colored dried liquid splattered on them. The screen of the feeding pump had dried tan colored liquid that had ran down the screen. The tube feeding pump was in use at that time. On 8/14/17 at 12:03 p.m., Resident B's white colored tube feeding pump had been partially cleaned. It had a small amount of dried tan colored liquid splattered on the feeding pump and the metal base with metal legs and wheels. The tube feeding pump was in use at that time/		leadership team & housekeeping staff that poles/pumps are to be cleaned daily. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** DON or designee will complete audits on all pumps/poles 2Xs weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months to ensure tube feeding pumps and poles are clean. Audit findings will be presented to the QAA Committee monthly x 3 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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	3. At 6:04 p.m., Resident F's white colored tube feeding pump had a small amount of dried tan colored liquid, which had ran down onto the metal pole, which the feeding pump was clamped onto, and the feeding pump and the metal base with metal legs and wheels had a dried tan colored liquid splattered on them. The tube feeding pump was in use at that time. At 12:32 p.m., Resident F's white colored tube feeding pump had a small amount of dried tan colored liquid splattered on the feeding pump. The tube feeding pump was in use at that time. 4. At 6:10 p.m., Resident C's white colored tube feeding pump had a moderate amount of dried tan colored liquid, which had ran down onto the metal pole, which the feeding pump was clamped onto, and the feeding pump and feeding pump screen and the metal base with metal legs and wheels and the dried tan colored liquid splattered on them. The tube feeding pump was in use at that time. On 8/14/17 at 12:46 p.m., Resident C's white colored tube feeding pump had a small amount of dried tan colored liquid, which was splattered onto the pump and the metal base with metal legs and			

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	wheels. The tube feeding pump was in use at that time. During an interview on 8/14/17 at 5:15 p.m., the Director of Nursing indicated she was aware the residents' tube feeding pumps were dirty with tube feeding on them. She indicated it was housekeeping's responsibility to clean the tube feeding pumps daily and she called a housekeeper to have him clean all four of the feeding pumps. 3.1-19(f)			