STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155261	A. BUILDING 00 B. WING	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSBURG HEALTH CARE	1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 17, 18, 19, 22, 23, and 24, 2018 Facility number: 000162 Provider number: 155261 AIM number: 100284300 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 1 Medicaid: 40 Other: 8 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 2, 2018.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health Care that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health Care.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident's transfer status was kept private for 1 of 24 residents reviewed for dignity (Resident 23). Findings include: On 10/17/18 at 1:39 p.m., Resident 23 was observed in his room. In the hallway, next to the	F 0550	**F550 – Resident Rights/Exercise of Rights** I. The name plate for Resident #23 was updated to the appropriate code on 10/19/18. II. In an effort to identify others who may have been affected in regard to privacy as it relates to information on the name plate, an	11/23/2018

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	resident's door was a name plate with the resident's name. Below the resident's name, on the name plate, was a label stated, "Stand lift." The label was clearly visible to anyone in the hallway. On 10/18/18 at 1:09 p.m., the stand lift label remained on the resident's name plate, in the hallway. On 10/19/18 at 9:41 a.m., the stand lift label remained on the resident's name plate, in the hallway. The resident's record was reviewed on 10/18/18 at 1:27 p.m. An admission Minimum Data Set (MDS) assessment, dated 8/3/18, indicated the resident had a moderate cognitive impairment and required an extensive assist of two staff members for transfers. A nursing summary, dated October 2018, indicated the resident required an extensive assist with transfers, stand lift. During an interview, on 10/19/18 at 10:24 a.m., the Quality Improvement Manager indicated the labels were placed on the doors about three to six months ago so the agency staff was aware of resident's transfer status. The resident required a stand lift to transfer. The label should have said, "SL," for stand lift instead of the words typed all the way out. The code should have been used to maintain the resident's dignity and privacy. During an interview, on 10/19/18 at 10:30 a.m., the Administrator indicated the transfer status on the resident's name plate should have been a code. Stand lift should not have been written all the way out. The codes were used to maintain the resident's privacy.		audit of all resident name plates was completed and changes made as applicable to ensure privacy. III. As a means to ensure ongoing compliance with ensuring residents' privacy on their name plates, the Administrator or designee will conduct monthly rounds of the building to ensure no private information is visible on the name plate. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	On 10/19/18 at 11:05 a.m., the Quality Improvement Manager provided a document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "The resident has a right to a dignified existence...Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal medical records...." 3.1-3(a) 3.1-3(o)			
F 0568 SS=E Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to ensure residents or their representatives received a quarterly statement for resident trust accounts for 4 of 4 residents reviewed for personal funds (Residents 12, 47, 14, and 15) with the potential to affect 16 residents with resident trust accounts. Findings include:	F 0568	**F568 Accounting and Records of Personal Funds** I. Residents 12, 47, 14, and 15 were issued written personal funds statements on 11/08/18. II. As all 15 residents for whom the facility manages funds could be affected, written notices of the account balances were issued to the resident and/or their	11/23/2018

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	a. During an interview, on 10/17/18 at 10:53 a.m., Resident 12 indicated he was not provided with a quarterly statement for his resident trust account. At the same time the resident's mother indicated she had not received any quarterly statements for the resident's trust account. Resident 12's record was reviewed on 10/23/18 at 1:30 p.m. An annual Minimum Data Set (MDS) assessment, dated 7/15/18, indicated the resident was cognitively intact. b. During an interview, on 10/17/18 at 1:46 p.m., Resident 47 indicated she had not received a quarterly statement for her resident trust account. Resident 47's record was reviewed on 10/19/18 at 2:27 p.m. A quarterly MDS assessment, dated 9/29/18, indicated the resident was cognitively intact. c. During an interview, on 10/17/18 at 1:54 p.m., Resident 14 indicated she was not provided with a quarterly statement for her resident trust account. Resident 14's record was reviewed on 10/23/18 at 2:00 p.m. A quarterly MDS assessment, dated 7/23/18, indicated the resident was cognitively intact. d. During an interview, on 10/17/18 at 2:26 p.m., Resident 15 indicated she had not received a quarterly statement for her resident trust account since she had been in the facility. Resident 15's record was reviewed on 10/23/18 at 9:26 a.m. An annual MDS assessment, dated 7/26/18, indicated the resident was cognitively intact.		representative. III. As a means to ensure ongoing compliance, the Administrator will confirm with the Social Services Director or designee to ensure that written resident account balances are issued at the end of each quarter ie December 2018, March 2019, June 2019, September 2019, and so on. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	During an interview, on 10/23/18 at 1:50 p.m., the Administrator indicated the resident trust account statements were sent to her by e-mail each quarter by accounts payable. The information was then relayed to the Social Services Director (SSD). The SSD then went around to each resident to verbally provide balance information or the SSD called their representatives if applicable. She did not think the statements were provided in writing. During an interview, on 10/23/18 at 2:08 p.m., the SSD indicated she had not notified any residents of their resident trust account balances unless they had requested it. She had not called any resident representatives with resident trust account balances. She had not routinely gone over any balances with the residents for their resident trust accounts. During an interview, on 10/23/18 at 2:10 p.m., the Administrator indicated there was no facility policy for quarterly statements for resident trust accounts. During an interview, on 10/24/18 at 9:19 a.m., the Administrator indicated the quarterly statements for resident trust accounts had not been provided in writing to the residents. She was aware of the issue. The quarterly statements should have been provided in writing. The residents were notified of their resident trust account balances verbally, if they asked. 3.1-6(g)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in			

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	or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			

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	Based on interview, and record review, the facility failed to ensure a resident's code status matched on the physician orders for scope of treatment (post) form and the physician's order for 1 of 24 residents reviewed for code status (Resident 48). Findings include: Resident 48's record was reviewed on 10/17/18 at 2:43 p.m. The resident was admitted to the facility on 1/6/18. A signed post form, dated 8/2/18, indicated the resident was a full code, to attempt cardiopulmonary resuscitation (CPR). At this time the physician's orders were reviewed, the physician's orders, dated October 2018, indicated the resident was a do not resuscitate (DNR). During an interview, on 10/22/18 at 1:48 p.m., the Administrator indicated the residents signed post form and physician's order should match for code status. She was unsure why the code status was not updated on the physician's orders to match the post form. During an interview, on 10/24/18 at 11:25 a.m., Resident 48 indicated he had signed a full code status form and wanted CPR. On 10/22/18 at 2:05 p.m., the Administrator provided a document titled, "Procedure for CPR-Cardiopulmonary Resuscitation," and indicated was the policy currently being used by the facility. The policy indicated, "Purpose: The facility shall provide basic life support, including CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders...Objective of the CPR policy: The objective of the CPR policy is to provide basic life support based until emergency	F 0578	**F578** **Request/Refuse/Discontinue Treatment; Formulate Advanced Directives** I. Resident 48's physician orders were updated to match his wishes as expressed on his POST form. II. In an effort to identify others who may have been affected in regard to non-matching code status, the DON performed an audit of all residents' physician's orders to ensure they match the resident's POST form and changes made as applicable. III. As a means to ensure ongoing compliance, staff received in-service training in regard to notification of Administrative nursing staff and the pharmacy when a resident changes their code status. The DON or designee will monitor physician's orders monthly to ensure the code status matches that on the resident's POST. Should concerns be noted re-education and/or disciplinary action shall be taken as warranted. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	11/23/2018

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	medical services arrives, consistent with the resident advance directives...Overview of Components of The Policy: Requirements for CPR: 1. Personnel must provide basic life support, including CPR, to a resident who requires such emergency care prior to arrival of emergency medical personnel: a. Subject to related physicians orders. b. Consistent with the resident's Advance Directives...." 3.1-4(f)(5)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as			

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	practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy			

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	of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure a notice of transfer or discharge was sent to the State Long-Term Care Ombudsman for 3 of 3 residents reviewed for discharges (Resident 54, Resident 44, and Resident 43), and a notice of transfer or discharge was provided to the resident or responsible party	F 0623	**F623 Notice Requirements Before Transfer/Discharge** I. Please note that residents #54, #44, and #43 were not negatively affected as a result of the failure to notify the Ombudsman of their transfer/discharge.	11/23/2018

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	at the time of a transfer to the hospital for 1 of 2 residents reviewed for hospitalizations (Residents 43). Findings include: 1. Resident 54's record was reviewed on 10/24/18 at 10:51 a.m. A physician's discharge summary indicated the resident was discharged from the facility to home on 7/19/18. At this time, no documentation was found that indicated the Ombudsman was notified of the resident's discharge. During an interview, on 10/24/18 at 11:10 a.m., the Administrator indicated the facility had failed to notify the Ombudsman of the resident's discharge from the facility. She had been aware the Ombudsman should have been notified, but had failed to do so.2. On 10/19/18 at 11:44 a.m. a medical record review for Resident 44 was completed. Copies of the following documents were provided by the Administrator on 10/19/18 at 2:40 p.m. A physician order to obtain a chest X-Ray, dated 10/12/18. A nursing progress note, dated 10/12/18 at 11:00 a.m., indicated Resident 44 left the facility to go to the hospital for a chest X-Ray. During an interview on 10/19/18 at 10:20 a.m. LPN 12 indicated Resident charts had pre-prepared transfer packets right in the front, so that if a resident has to go out, staff could just pull the packet and fill out a few additional things at the time of the transfer. She indicated the packet included information regarding the facility bed-hold policy but did not know about		II. In an effort to identify others who may have been affected in regard to notification of the Ombudsman of transfers/discharges all resident transfers and discharges for the previous 30 days were audited and notification of the Ombudsman made. III. As a means to ensure ongoing compliance with notification of the Ombudsman of transfer/discharges, the Administrator will conduct weekly checks with the Social Services Director to ensure timely submission of records of any transfers/discharges that occurred that week. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	notification to the Ombudsman.3. Resident 43's record was reviewed on 10/22/18 at 10:14 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/9/18, indicated the resident was cognitively intact and had one fall with major injury since the prior assessment. Diagnoses on the resident's profile included, but were not limited to, presence of right artificial hip joint and history of falling. A nurse's note, dated 7/22/18 at 4:45 a.m., indicated the resident was lowered to the floor by the aide during a transfer from the bedside commode to the bed. The resident reported she lost her balance. No evident injuries were noted. The resident complained of mild pain and soreness to the left hip and was assisted back to bed. The resident's blood pressure was 96/50, normal range 120/80-140/90. The physician was to be contacted for further instructions. The note lacked documentation the physician was contacted at that time. A nurse's note, dated 7/22/18 with no time documented, indicated the nurse was notified upon arrival the resident fell at 5:00 a.m. The resident was in pain. The previous charting stated the resident's blood pressure was low, but was normal at 148/78 when this nurse checked. The resident complained of left hip pain at an 8 out of 10, on the pain scale. The physician was contacted, and the resident was transferred to the ER. The note lacked documentation the resident or resident's representative was provided with a notice of transfer or discharge or the Ombudsman was notified of the hospital transfer. A nurse's note, dated 8/2/18, indicated the resident returned to the facility.			

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	155261	A. BUILDING 00 B. WING	10/24/2018

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The resident's paper chart was reviewed and lacked documentation the resident or resident's representative was provided with a notice of transfer or discharge or the Ombudsman was notified of the hospital transfer.

During an interview, on 10/22/18 at 2:58 p.m., the Administrator indicated there should have been a transfer packet completed at the time of the hospital transfer. The transfer packet included the notice of transfer or discharge that should have been provided to the resident or resident representative.

During an interview, on 10/22/18 at 10:13 a.m., the Administrator indicated she was unable to find any transfer paperwork had been completed for the resident. She was unable to find any documentation the notice of transfer or discharge was provided to the resident or the resident's representative. The Ombudsman was not notified of the hospital transfer. She had not started with the Ombudsman notification of all hospital transfers and discharges yet. She was aware it needed to be done, but she had not had time to start yet.

During an interview, on 10/23/18 at 11:37 a.m., the Quality Improvement Manager indicated the resident rights were used as the policy for transfers, discharges, and Ombudsman notification.

On 10/19/18 at 11:05 a.m., the Quality Improvement Manager provided a document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Notice before transfer. Before a facility transfers or discharges a resident, the facility

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	must- (i) Notify the resident and the resident representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman...." On 10/23/18 at 10:57 a.m., the Director of Nursing provided a packet titled, "Resident transfer form instructions," and indicated it included information that should have been completed with all hospital transfers. The packet indicated, "This document contains 5 pages...2. State Notice of transfer or discharge. 3. State notice of transfer or discharge request for hearing...All of these forms are a direct State requirement for compliance. Complete all forms and a copy is to be placed in the mailbox of Social Services." The packet included the forms titled, "NOTICE OF TRANSFER OR DISCHARGE," and, "NOTICE OF TRANSFER OR DISCHARGE REQUEST FOR HEARING." 3.1-12(a)(8)(D) 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a			

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	hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure a bed hold policy was provided with a hospital transfer for 1 of 2 residents reviewed for hospitalizations (Resident 43). Findings include: Resident 43's record was reviewed on 10/22/18 at 10:14 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/9/18, indicated the resident was cognitively intact and had one fall with major injury since the prior assessment. Diagnoses on the resident's profile included, but were not limited to, presence of right artificial hip	F 0625	**F625 Notice of Bed Hold Policy Before/Upon Transfer** I. Please note that resident #43 was not negatively affected as a result of the failure to notify of the bed hold policy. II. As all residents who are transferred could be affected the following corrective action was taken: III. As a means to ensure ongoing compliance with issuing notifications of the bed hold policy upon transfer, licensed nursing staff received in-servicing on	11/23/2018

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	joint and history of falling. A nurse's note, dated 7/22/18 at 4:45 a.m., indicated the resident was lowered to the floor by the aide during a transfer from the bedside commode to the bed. The resident reported she lost her balance. No evident injuries were noted. The resident complained of mild pain and soreness to the left hip and was assisted back to bed. The resident's blood pressure was 96/50, normal range 120/80-140/90. The physician was to be contacted for further instructions. The note lacked documentation the physician was contacted at that time. A nurse's note, dated 7/22/18, with no time documented, indicated the nurse was notified upon arrival the resident fell at 5:00 a.m. The resident was in pain. The previous charting stated the resident's blood pressure was low, but was normal at 148/78 when this nurse checked. The resident complained of left hip pain at an 8 out of 10, on the pain scale. The physician was contacted, and the resident was transferred to the ER. The note lacked documentation the resident or resident's representative was provided with a bed hold policy at the time of the hospital transfer. A nurse's note, dated 8/2/18, indicated the resident returned to the facility. The resident's paper chart was reviewed and lacked documentation the resident or resident's representative was provided with a bed hold policy at the time of the hospital transfer. During an interview, on 10/22/18 at 2:58 p.m., the Administrator indicated there should have been a transfer packet completed at the time of the hospital transfer. The transfer packet included the		completing the forms and the procedure to follow with the forms. Upon resident transfer, the Social Services Director will monitor to ensure appropriate issuance of the notice. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	bed hold policy that should have been provided to the resident or resident representative. During an interview, on 10/22/18 at 10:13 a.m., the Administrator indicated she was unable to find any transfer paperwork had been completed for the resident. She was unable to find any documentation the bed hold policy was provided to the resident or the resident's representative. During an interview, on 10/23/18 at 11:37 a.m., the Quality Improvement Manager indicated the resident rights were used as the policy for the bed hold policy with hospital transfers. On 10/19/18 at 11:05 a.m., the Quality Improvement Manager provided a document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Notice of bed hold policy and return. (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital...the nursing facility must provide written information to the resident or resident representative that specifies-(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan... (iii) The nursing facility's policies regarding bed-hold periods...." On 10/23/18 at 10:57 a.m., the Director of Nursing provided a packet titled, "Resident transfer form instructions," and indicated it included information that should have been completed with all hospital transfers. The packet indicated, "This document contains 5 pages...4. Bed Hold policy...All of these forms are a direct State requirement for compliance. Complete all forms and a copy is to be placed in the mailbox of Social			

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	Services." The packet contained a document titled, "BED HOLD POLICY." 3.1-12(a)(25) 3.1-12(a)(25)(A) 3.1-12(a)(25(B) 3.1-12(a)(26)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to accurately code Minimum Data Set (MDS) assessments for a resident's falls (Resident 6), a resident's weight gain (Resident 18), and a resident's use of antipsychotic medications (Resident 23) for 3 of 19 residents reviewed for MDS accuracy. Findings include: 1. On 10/17/18 at 11:42 a.m., Resident 6 was observed sitting in her wheelchair in her room. A Transfer pole from floor to ceiling was observed on the right side of her bed, (as the left side was to the wall), and non-skid grip stickers were observed on the floor side her bed near the pole. Resident 6 indicated she had experienced several falls and blamed her disease process for her unsteadiness. On 10/22/18 at 10:48 a.m., a record review for Resident 6 was completed. Copies of the following documents were provided by the Administrator on 10/22/18 at 1:33 p.m. A most recent comprehensive assessment was an	F 0641	**F641 Accuracy of Assessments** I. 1-3. The MDS assessments of Residents 6, 18 and 23 have been corrected. II. 1-3. In an effort to identify others who may have been affected, a review will be conducted of all MDSs completed since July 1, 2018 to confirm accuracy in resident falls, weight gain vs. loss and antipsychotic medication use. III. As a means to ensure ongoing compliance, at the time of MDS review, the DON/designee shall review and confirm the Minimum Data Set adequately addressed the current health and status of the resident, including but not limited to falls, weight gain vs. loss, and antipsychotic medication use. Should concerns be identified, corrective action shall be taken. The DON/designee shall sign to indicate review of the MDS to confirm said review. IV. As a mean of quality assurance, results of the	11/23/2018

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	annual MDS assessment dated, 10/17/18. (Prior to that, a quarterly MDS assessment had been completed on 7/17/18). The current MDS indicated Resident 6 was cognitively intact, and had diagnosis to include, (but were not limited to), Parkinson's disease, and Tremors. The MDS indicated Resident 6 had had only 1 fall since the prior assessment. A nursing progress note, dated 9/9/18 at 2:15 a.m., indicated "...resident on the floor next to bed...." A second progress note, dated 9/9/18 at 9:20 a.m., indicated, "... resident laying on the floor in front of closet...." A fall investigation report, dated 9/9/18 at 2:20 a.m., was completed. A second fall investigation report, dated 9/9/18 at 9:20 a.m., was completed. During an interview with the MDS Coordinator on 10/23/18 at 1:56 p.m., she indicated, The MDS was coded incorrectly, and should have indicated the reflection of 2 falls since the prior assessment according the RAI (Resident Assessment Instrument) manual. She indicated the resident had fallen twice in one day, and it had been overlooked. 2. Resident 18's record was reviewed on 10/23/18 at 1:40 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/3/18, indicated the resident had a moderate cognitive impairment and a significant weight loss of 5 percent or more in the last month or 10 percent or more in the last 6 months, and was not on a physician-prescribed weight loss program. A face sheet indicated the resident was admitted		aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	to the facility on 4/26/18. Review of the Weight Record: a. 4/26/18, 85.2 pounds. b. 5/2/18, 87.4 pounds. c. 5/14/18, 90.6 pounds. d. 6/6/18, 89.2 pounds. e. 6/19/18, 87.8 pounds. f. 7/2/18, 88.4 pounds. g. 7/16/18, 92.7 pounds. h. 8/10/18, 95.5 pounds. i. 8/24/18, 99 pounds. j. 8/31/18, 100.2 pounds. k. 9/21/18, 98.2 pounds. l. 10/8/18, 102 pounds. During an interview, on 10/23/18 at 1:46 p.m., Licensed Practical Nurse (LPN) 9 indicated the resident had gained weight since admission, she had not lost weight. During an interview, on 10/23/18 at 2:35 p.m., the MDS Coordinator indicated the resident had gained weight at the time of the assessment. The quarterly MDS assessment, dated 8/3/18, should have indicated a weight gain, not a weight loss. It was coded incorrectly.			

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	A copy of Section K of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 10/23/18 at 2:59 p.m. The manual indicated, "...K0300: Weight Loss...Coding Instructions...Code 0, no...if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days...K0310: Weight Gain...Code 2, yes, note on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician...." 3. Resident 23's record was reviewed on 10/18/18 at 1:27 p.m. An admission Minimum Data Set (MDS) assessment, dated 8/3/18, indicated the resident had a moderate cognitive impairment and received an antipsychotic (medications used to treat psychotic disorders) medication 7 days of the look-back period. Section N0450A, Antipsychotic Medication Review, indicated the resident had not received an antipsychotic medication. Diagnoses on the resident's profile included, but were not limited to, vascular dementia (a common form of dementia caused by an impaired supply of blood to the brain) with behavioral disturbances. A physician's order, dated 7/27/18, indicated quetiapine (an antipsychotic) 25 milligrams (mg) by mouth every 12 hours. During an interview, on 10/19/18 at 2:10 p.m., the MDS Coordinator indicated the resident received an antipsychotic medication daily. Section N0450 on the admission MDS assessment, dated 8/3/18,			

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	should have indicated the resident received an antipsychotic medication on a routine basis. A copy of Section N of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 10/19/18 at 2:15 p.m. The manual indicated, "SECTION N: MEDICATIONS...N0450A...Code 1, yes: if antipsychotics were received on a routine basis only...." 3.1-31(c)(2) 3.1-31(c)(13)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure care plans were developed for residents' medical needs (Residents 23 and 37) and to remove an intervention from a care plan (Resident 8) for 3 of 14 residents reviewed for care plans. Findings include: 1. Resident 23's record was reviewed on 10/18/18 at 1:27 p.m. An admission Minimum Data Set (MDS) assessment, dated 8/3/18, indicated the resident had a moderate cognitive impairment and diagnoses of gastroesophageal reflux disease (GERD) (a digestive disease in which stomach acid or bile irritates the food pipe lining) and idiopathic gout (a form of arthritis characterized by severe pain, redness, and tenderness in joints). A physician's order, dated 7/27/18, indicated	F 0656	**F656 Develop/Implement Comprehensive Care Plan** I. 1-3. The care plans of Residents #23, #37, and #8 have been revised and updated to include diagnoses with corresponding medications/treatments, and appropriate incontinence interventions. II.1-3. In an effort to identify others who may have been affected, a review will be conducted of all care plans to confirm diagnoses with corresponding medications/treatments and incontinence interventions are addressed to ensure staff awareness of conditions and necessary care thereof. III. As a means to ensure ongoing	11/23/2018

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	pantoprazole (a medication to treat GERD) delayed release (DR) 20 milligrams (mg) by mouth every morning before a meal for reflux. A physician's order, dated 7/27/18, indicated allopurinol (a medication to treat gout) 100 mg by mouth twice daily after meals for gout. Current care plans lacked documentation of a care plan for GERD or gout. During an interview, on 10/19/18 at 1:54 p.m., the Quality Improvement Manager indicated if a resident had a diagnosis and was medicated for the diagnosis there should have been a care plan developed. 2. Resident 37's record was reviewed on 10/18/18 at 1:40 p.m. Diagnoses on the resident's profiled included, but were not limited to, anemia (a condition in which the blood doesn't have enough healthy red blood cells), hypokalemia (a low level of the electrolyte potassium in the blood), and chronic constipation (infrequent bowel movements, and small, hard to pass, stool). A review of the most current care plans, lacked documentation of care plans for anemia, hypokalemia, and chronic constipation. A Medication Administration Record (MAR), dated October 2018, indicated the resident received the following medications: a. ferrous sulfate 325 milligrams (mg), start date 2/3/14, take 1 tablet by mouth for iron deficiency. b. potassium chloride extended release (ER) 20 milliequivalents (MEQ), start date 3/2/18, take 1 tablet orally 2 times daily for potassium replacement.		compliance, the care plan coordinator has been educated in regard to developing a comprehensive care plan, including, but not limited to, medications and skin conditions. IV. As a means of quality assurance, at the time of care plan review for significant change in condition or quarterly review, the DON/designee shall review and confirm the comprehensive care plan adequately addressed the current health and status of the resident, including but not limited to relevant health conditions. Should concerns be identified, corrective action shall be taken. The DON/designee shall sign to indicate review of the care plan to confirm said review. Results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	155261	A. BUILDING 00 B. WING	10/24/2018

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c. docusate 100 mg, start date 2/24/14, take 1 capsule by mouth 2 times daily for stool softener.

During an interview, on 10/19/18 at 11:06 a.m., the Care Plan Coordinator indicated the resident should have been care planned for the use of an iron supplement, potassium, and a stool softener and the resident's current diagnoses.

3. Resident 8's record was reviewed on 10/19/18 at 11:24 a.m. A care plan, target date 12/19/18, indicated the resident was always incontinent of bladder and was to be checked and changed at least every two hours per staff. An intervention, effective date 3/1/18, indicated to encourage the resident to decrease fluid intake at bedtime to decrease nighttime incontinence episodes.

During an interview, on 10/19/18 at 11:18 a.m., Certified Nursing Assistant (CNA) 13 indicated the resident required total dependence for care. The resident was incontinent of bladder and was checked and changed as needed at least every two hours.

During an interview, on 10/22/18 at 11:24 a.m., the Administrator indicated the resident's plan of care should not have indicated to encourage the resident to limit fluid intake at night to decrease nighttime incontinence. She was not aware of the resident having concerns with being incontinent at night.

On 10/19/18 at 1:45 p.m., the Administrator provided a document titled, "Care planning," and indicated was the policy currently being used by the facility. The policy indicated, "...The care plan is a list of goals for meeting the resident's medical, emotional and social needs and tells how those

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	needs will be met...Problems include medical, emotional, psycho-social, behaviors, falls, skin issues, etc. 3.1-35(a) 3.1-35(b)(1)			
F 0684 SS=G Bldg. 00	483.25 Quality 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. Based on observation, interview, and record review, the facility failed to protect 2 of 5 residents from sustaining a major injury, resulting in harm after falls when staff failed to call 911 immediately and assess a resident with a head injury prior to moving the resident after a fall resulting in a subdural hematoma and subarachnoid hemorrhage (Resident 151), and when staff failed to transfer a resident by a lift resulting in a left rib fracture (Resident 44). The facility failed to follow policy to protect 2 of 5 residents from the potential of harm after a fall by not appropriately assessing the residents post fall, not following the facility's lift policy, and not following care plans of the residents at the time of their falls (Residents 6, and 43). Findings include: 1. Resident 151's record was reviewed on 10/23/18 at 10:38 a.m. Diagnoses on the resident's profiled	F 0684	**F684 Quality of Care** I. No corrective action can be taken relative to Resident #151. The plans of care for residents #44, #6 and #43 were reviewed to ensure fall interventions and transfer status remain appropriate accurate for the individual resident. II. As all residents could be affected, transfer status of all residents will be reviewed to ensure necessary assistance is accurately addressed on the plan of care for reference by caregivers. The facility policies addressing immediate actions following a witnessed or unwitnessed fall will be reviewed to confirm adherence with current standards of practice. All nursing staff shall receive inservice education addressing	11/23/2018

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	included, but were not limited to, legal blindness, repeated falls, generalized muscle weakness, difficulty in walking, and osteonecrosis (death of bone tissue due to lack of blood supply) of right femur. A document, titled, "Fall Investigation Report," dated 7/29/18 at 1:45 p.m., indicated the resident had a fall and was found on her right side on the floor. The resident was noted to have attempted to change her clothes without assistance and slipped forward out of her wheelchair. The report lacked documentation vital signs were obtained before transferring the resident to the bed. A nursing summary, dated 7/29/18 with no time noted, indicated the resident was found on the floor on the right side of her face, with bright red blood noted on the floor. The resident sat up and a cut was noted to her right eyebrow and a small hematoma on the middle of her forehead, she grabbed at staff and was anxious. The resident was lifted onto the bed, and when calmed down vital signs were taken and neuro checks were completed. At the same time, another nurse called the physician and an order was obtained to send the resident to the emergency department to be evaluated and treated. A nurse's note, dated 7/29/18 at 2 p.m., indicated a noise was heard from the resident's room and resident was found on her right side on the floor. A laceration was noted to the right eyebrow from hitting her glasses and a hematoma noted above that. Resident had complaint of pain to the right hip and right shoulder, and was unable to assess range of motion due to the resident yelling in pain. Neuro checks (check for level of consciousness) were within normal limits and physician was called and gave order to send to emergency department		post fall intervention, including but not limited to, not moving a resident until fully assessed by a nurse, the obtaining of vital signs and conducting of neuro checks (if warranted) prior totransfer/move, appropriately moving the resident via mechanical device if indicated, physician and representative notification and documentation of all actions taken as per policy. III. As a means to ensure ongoing compliance with provision of appropriate assessment and care following a witnessed or unwitnessed fall, the DON/designee shall be contacted immediately following any witnessed/unwitnessed fall. The DON/designee shall review nursing actions with the reporting nurse to confirm adherence with facility policy. Should non-compliance be identified, immediate corrective and/or disciplinary action shall be taken. Additionally, documentation of all post fall actions shall be reviewed at each morning meeting following the fall/incident to confirm the following of policy and documenting of all actions taken and notifications made. Should non-compliance be identified, immediate corrective and/or disciplinary action shall be taken. Non-compliance and corrective actions shall be recorded for tracking purposes to identify patterns/trends and to conduct	

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	for evaluation and treatment. Ambulance service was called and transported resident to the emergency room via gurney. A Physician's order, dated 7/29/18, indicated to send the resident to the emergency room for evaluation and treatment. A Physician's discharge summary, dated 7/29/18 at 2 p.m., indicated the resident had a history of falls and was admitted to the hospital post fall and final diagnoses were subdural hematoma and hip fracture with a fair prognosis. A hospital progress note, dated 7/29/18 at 7:02 p.m., indicated the resident suffered a fall that day. The resident appeared to be in pain with moaning and grasping at the time of arrival to the emergency department. A cat scan to the lower extremity revealed an acute right introchanteric (femur) to subtrochantric fracture, a cat scan to the head revealed right frontal temporal parietal subdural hematoma (a pool of blood between and its outermost covering) with mild leftward midline shift subfalcine herniation (displacement of the brain) with right temporal and posterior subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). At this same time, with the severity of the resident's condition the resident's family made the determination to make the resident comfort measures. An Indiana State Department of Health Certificate of Death, dated 8/7/18, indicated the resident's date of death was 7/31/18 at 1:00 a.m. The immediate cause of death listed was subdural hematoma, and subarachnoid hemorrhage. A care plan, revised on 6/12/18, indicated the		root cause analysis, in an effort to implement necessary performance improvement initiatives upon discovery. IV. As a means of quality assurance, aforementioned tracking, root cause analysis and any corrective actions taken as a result shall be reported by the DON to the Quality Assurance Committee on a quarterly basis and will continue ongoing until 100% compliance with adherence to facility policy is evident for no less than 6 months. V. Correction Date: 11/23/18	

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	resident was at risk for falls due to gait disturbance related to weakness and was a limited assistance with walking. Interventions included, but were not limited to: continue to monitor and follow proper fall precautions. An activities of daily living tracking form, dated July 2018, indicated from 7/5/18 to 7/24/18 the resident was a limited assist of one person for transfers. On 7/25/18 to 7/28/18 the resident's transfer status changed to an extensive assist of two or more for transfers. An annual Minimum Data Set (MDS), dated 5/20/18, indicated the resident was a limited assist of one person for transfers. During an interview, on 10/23/18 at 1:57 p.m., the Quality Improvement Manager indicated the resident was transferred to her bed after the fall on 7/29/18 and should not have been moved with a head injury and suspected fracture. When a head injury occurred, 911 should have been called first because it was an emergency situation. Vital signs should have been obtained before transferring the resident to her bed, and no documentation was found to support they had been, only documentation they had been obtained after the resident was transferred. She indicated she was unaware the resident had a change in transfer status from 7/25/18 to 7/28/18 and that should have been reported as a change of condition for the resident and was not. 2. On 10/17/18 at 10:24 a.m., during an initial tour through the building, Resident 44 was not observed in her room, and CNA 15 indicated Resident 44 was out at the hospital. A closed record review for Resident 44 was completed on 10/19/18 at 11:44 a.m. Copies of the			

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	following documents were provided by the Administrator (ADMN) 10/19/18 at 2:40 p.m. A fall investigation report dated 10/8/18 at 1:30 a.m. indicated, "... Res. [Resident] reported that she fell and was found on the floor of her room by staff and assisted up by 2 staff... Res. voicing c/o [complaint of] rib/back pain. No bruising or injuries observed other than a 'knot' on right forearm 3 cm [centimeters] x 4 cm and is flesh colored, not tender, and no discoloration...." At the time of the fall, there was no nursing note documentation. Nursing notes after the fall were reviewed: a. 10/8/18 at 7:45 a.m. was documented late, on 10/8/18 at 10:29 a.m. The progress note indicated, "... Resident reported to staff this morning that she fell... notification prepared for MD [Medical Director]. Will follow up x 72 hours...." b. 10/8/18 at 10:00 p.m., "...no injuries noted r/t [related to] previous fall... Resident complains of left wrist pain... Resident complains of being sore...." c. 10/9/18 at 5:30 a.m., "...Resident up in her recliner and complains of pain all over. Barley able to move with feeling the pain in her left side, back and shoulders...." d. 10/9/18 at 9:45 a.m., "... Resident continues to complain about left ribs hurting, called Dr. at this time and NO [new order] received for chest X-ray to rule out left rib fracture...." e. 10/9/18 at 2:00 p.m., "... report received negative results...." f. 10/10/18 at 8:15 a.m., "...continues to voice complaints of left rib pain from previous fall...." g. 10/10/18 at 12:45 p.m., "...ambulance here to transport Resident to the hospital to have X-rays...." h. 10/10/18 at 3:15 p.m., "... Notified POA (power			

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	of attorney) of results from X-ray of left ribs...." The hospital X-ray summary, dated 10/10/18 indicated, "... moderately displaced left seventh rib fracture...." During an interview with the ADMN on 10/19/18 at 1:28 p.m., she indicated Resident 44 had sustained a rib fracture after a fall in her room, due to an incorrect transfer. The ADMN indicated, the fall happened early in the morning on 10/7/18, and she only found out about the Resident's fall, after arrived at work the next morning. The ADMN indicated, the nurse on duty at the time of the fall (LPN 16) had not called to notify her (the ADMN), the Doctor, or the resident's family. The ADMN indicated after she initiated a fall investigation, she had discovered the following: LPN 16 was notified about the resident's fall from a CNA (Certified Nursing Assistant) who found the resident. LPN 16 had instructed two CNAs to get the resident off the floor using a gait belt, instead of a mechanical lift, as the facility policy required, and the use of the gait belt had resulted in the resident sustaining a rib fracture. A record of Discipline and the summary of termination for LPN 16 indicated, on 10/7/18 Resident 44 sustained a fall in her room at approximately 9:11 p.m. CNA 17 alerted LPN 16, who was the charge nurse, of resident's fall, however, LPN 16 continued to complete duties at med cart with no urgency exhibited to proceed to resident's room to assess for injury. LPN 16 was never observed going into resident's room to assess resident and failed to follow the facility policy as evidence by the following: not initiating neurochecks, not following lift policy, not completing fall investigation report, not documenting incident in the nurses' notes and			

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	failing to notify physician, DON (Director of Nursing), and family member regarding the fall. "... [LPN 16's] lack of judgement resulted in resident's injuries not being immediately identified and treated causing resident undue pain and suffering...." During an interview with the Administrator and DON on 10/19/18 at 2:24 p.m., the ADMN provided a copy of the Resident Fall Policy and indicated, Resident 44 should have immediately been assessed by the charge nurse, obtained vital signs at the time of the fall, and the resident should not have been moved without a mechanical lift. The charge nurse, LPN 16, should have contacted the Doctor as soon as possible to discuss possible treatment or orders, and she should have completed necessary documentation about the fall. 3. On 10/17/18 at 11:42 a.m., Resident 6 was observed sitting in her wheelchair in her room. A Transfer pole from floor to ceiling was observed on the right side of her bed, (as the left side was to the wall), and non-skid grip stickers were observed on the floor side her bed near the pole. Resident 6 indicated she had experienced several falls and blamed her disease process for her unsteadiness. On 10/22/18 at 10:48 a.m., a record review for Resident 6 was completed. Copies of the following documents were provided by the Administrator on 10/22/18 at 1:33 p.m. A most recent comprehensive assessment was an annual MDS assessment, dated 10/17/18. The MDS indicated Resident 6 was cognitively intact, and had diagnosis to include, (but were not limited to), Parkinson's disease, and Tremors, and			

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	had a history of falls since the last assessment. A fall investigation report, dated 9/9/18 at 2:20 a.m., was completed and indicated, "...Resident found next to bed in sitting position... writer and CNA transferred to recliner...." A second fall investigation report, dated 9/9/18 at 9:20 a.m., was completed and indicated, "... Resident found lying on the floor by her closet on left side...." no root cause, initial interventions, or care plan updates were documented on the fall report. A nursing progress note, dated 9/9/18 at 2:15 a.m., indicated "...resident on the floor next to bed.... writer and [CNA] were able to lift her up to her recliner, Resident started to yell we were pulling on her arms...." A second progress note, dated 9/9/18 at 9:20 a.m., indicated, "... resident laying on the floor in front of closet... laying on left side with left arm behind her... resident complains of left shoulder pain...." A current care plan in place at the time of Resident 6's fall indicated, "...I [Resident 6] am at risk for falls...." and, "... I [Resident 6] do experience behavioral disturbances on occasion and can be difficult to get along with. I like to be as independent as possible...." Care plan interventions in place at the time of Resident 6's fall included but were not limited to: "... staff is to never deter from safety protocol due to me [Resident 6] being belligerent of 'throwing a fit'.... review no lift policy of the facility with me. Explain that staff is not allowed per our policy to lift anything over 25 lbs. so if I fall they will not be able to lift me off the floor, I must be hoyered or the ambulance staff will come and pick me up to			

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	be transferred to the hospital...." During an interview with the ADMN on 10/22/18 at 11:51 a.m., she indicated, the interventions listed on Resident 6's care plan were affective at the time of her fall. The nurse, LPN 16, should not have moved the resident without a lift, and should always follow safety protocol according to facility policy. 4. Resident 43's record was reviewed on 10/22/18 at 10:14 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/9/18, indicated the resident was cognitively intact and had one fall with major injury since the prior assessment. Diagnoses on the resident's profile included, but were not limited to, presence of right artificial hip joint and history of falling. A return from therapy checklist, dated 7/5/18, indicated therapy recommended the resident be transferred to wheelchair or bedside commode with one staff assistance. A nursing summary, dated 7/11/18, indicated the resident required one staff assistance to transfer to the bedside commode. A Complete Metabolic Panel (CMP) (a blood test to check the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), dated 7/20/18, indicated a sodium (an electrolyte) level of 118, normal range 135-145. A physician's order, dated 7/20/18, indicated send the resident to the emergency room (ER) for evaluation and treatment if the resident had dizziness, confusion, or became unstable.			

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	A nurse's note, dated 7/22/18 at 4:45 a.m., indicated the resident was lowered to the floor by the aide during a transfer from the bedside commode to the bed. The resident reported she lost her balance. No evident injuries were noted. The resident complained of mild pain and soreness to the left hip and was assisted back to bed. The resident's blood pressure was 96/50, normal range 120/80-140/90. The physician was to be contacted for further instructions. The note lacked documentation the physician was contacted at that time. A nurse's note, dated 7/22/18, with no time documented, indicated the nurse was notified upon arrival the resident fell at 5:00 a.m. The resident was in pain. The previous charting stated the resident's blood pressure was low, but was normal at 148/78 when this nurse checked. The resident complained of left hip pain at an 8 out of 10, on the pain scale. The physician was contacted, and the resident was transferred to the ER. A nurse's note, dated 7/22/18 at 4:00 p.m., indicated the nurse spoke with hospital staff, and the resident was admitted with diagnoses of fractured left femur (thigh bone), hyponatremia (low sodium in the blood), and hypokalemia (low potassium in the blood). A physician notification form, dated 7/22/18 at 4:45 a.m., indicated the resident lost her balance during a transfer and fell to the floor with Certified Nursing Assistant (CNA) assistance. No evident injuries were noted. The resident complained of mild soreness to the left hip and was assisted back to bed. A follow up note, on the same form, on 7/22/18 at 12:30 p.m., indicated the resident was sent to the ER with diagnoses of fractured left			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	femur, hyponatremia, and hypokalemia. A fall investigation report, dated 7/22/18, indicated the resident fell at 4:45 a.m. The resident's blood pressure was 96/50. Factors which contributed to the fall included medical status or physical condition, and abnormal or significant vital signs. The resident's blood pressure may have contributed to the fall. An x-ray, dated 7/22/18, indicated a subtle impaction fracture (an impacted fracture occurs when the broken ends of the bone are jammed together by the force of the injury) to the transcervical region (middle part of the femur neck) left femur. A nurse's note, dated 8/2/18, indicated the resident returned to the facility. A care plan, target date 11/30/18, indicated the resident was at risk for falls and had fallen on 7/22/18. During an interview, on 10/22/18 at 11:41 a.m., the Director of Nursing (DON) indicated the physician notification form was a form filled out and placed in the communication binder to be reviewed when the physician came into the facility for his next visit. It was acceptable for the staff to notify the physician by the form if the resident had not been injured. The staff should have paged the physician and spoken to him for any falls with injury. She thought they should not have moved the resident from the floor after the fall if she complained of pain. During an interview, on 10/22/18 at 2:11 p.m., the Quality Improvement Manager indicated she was unable to find any documentation to support the			

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	155261	A. BUILDING 00 B. WING	10/24/2018

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	physician had been contacted before 12:30 p.m. on 7/22/18, to report the fall and the resident's complaints of pain. During an interview on 10/23/18 at 10:57 a.m., the DON indicated the resident fell on 7/22/18 at 4:45 a.m. The night shift nurse called the DON between 6:00 a.m. and 6:30 a.m., and notified her of the fall. At that time, the DON advised the night shift nurse to tell the day shift nurse to contact the physician with the assessment. At that point, the nurse had not yet spoken to the physician. The day shift nurse had not notified the physician because when she went to the resident's room, the resident was asleep. Another nurse came in at 10:00 a.m. The resident complained of pain, and the 10:00 a.m. nurse notified the physician after the start of the shift. She was unable to find any documentation the physician was contacted before 12:30 p.m. on 7/22/18. On 10/23/18 at 11:37 a.m., the Quality Improvement Manager provided a document titled, "Fallen Resident: Witnessed or Unwitnessed," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To assess a Resident noted to have had a witnessed or unwitnessed fall for injuries and provide treatment, as indicated. POLICY: Upon observing a fall (witnessed), or finding a Resident who has fallen (unwitnessed), the Resident will be assessed for injuries and emergency care provided. PROCEDURE: ...8...The nurse shall assess for sign/symptoms of fracture, dislocation or head injury. 9. Assist Resident to chair or to bed as indicated using the appropriate mechanical lift...The licensed nurse will notify the physician and family of falling incident...." 3.1-37(a)			

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement fall interventions, re-evaluate a resident for transfer assistance, and follow post fall procedures resulting in harm when a resident sustained a subdural hematoma and subarachnoid hemorrhage with an unwitnessed fall (Resident 151) for 1 of 5 residents reviewed for falls. The facility failed to protect 1 of 5 residents from the potential for harm related to falls by not assessing a resident's fall risk with a change in condition and updating a resident's transfer assistance requirements on the care plan (Residents 43). Findings include: 1. Resident 151's record was reviewed on 10/23/18 at 10:38 a.m. Diagnoses on the resident's profiled included, but were not limited to, legal blindness, repeated falls, generalized muscle weakness, difficulty in walking, and osteonecrosis (death of bone tissue due to lack of blood supply) of right femur. A fall investigation report, dated 2/4/18, indicated the resident had a fall. An intervention to assess usual toileting pattern at night was put in place to prevent future falls. A review of the fall care plan,	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** I. No corrective action can be taken relative to Resident #151. The plan of care for resident #43 was reviewed to ensure fall interventions and transfer status remain appropriate accurate for the individual resident. II. As all residents could be affected, transfer status of all residents will be reviewed to ensure necessary assistance is accurately addressed on the plan of care for reference by caregivers. The careplans of all residents identified as at risk for falls will be reviewed by the interdisciplinary team to confirm interventions remain appropriate, interventions have been implemented, and interventions have been communicated to caregivers. The facility policies addressing fall interventions, re-evaluation of transfer assistance/ communication to staff should	11/23/2018

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	lacked documentation of the implementation of the intervention. A quarterly Minimum Data Set (MDS), dated 2/23/18, indicated the resident had no falls since the last assessment. During an interview, on 10/23/18 at 2:34 p.m., the MDS Coordinator indicated the resident had a fall on 2/4/18. The quarterly MDS assessment dated 2/23/18 was coded incorrectly, and should have been coded as 1 fall since the last assessment. An annual Minimum Data Set (MDS), dated 5/20/18, indicated the resident was a limited assist of one person for transfers. A care plan, revised on 6/12/18, indicated the resident was at risk for falls due to gait disturbance related to weakness and was a limited assistance with walking. Interventions, initiated on 6/29/17 and revised on 6/12/18, indicated the resident received limited assistance with transfers and walking to reduce the risk of falls, and to place call light within reach with prompt responses to all requests. A fall investigation report, dated 6/17/18, indicated the resident had a fall. An intervention to put dycem (non slip material) in the seat of wheel chair was put in place to prevent future falls. A review of the fall care plan, lacked documentation of the new intervention. A fall investigation report, dated 6/23/18, indicated the resident had a fall. An intervention to offer the resident to lay down after meals was put in place to prevent future falls. A review of the fall care plan, lacked documentation of the new intervention.		said transfer status change, and immediate actions following a witnessed or unwitnessed fall will be reviewed to confirm adherence with current standards of practice. All nursing staff shall receive inservice education addressing post fall intervention, including but not limited to, not moving a resident until fully assessed by a nurse, the obtaining of vital signs and conducting of neuro checks (if warranted) prior to transfer/move, appropriately moving the resident via mechanical device if indicated, physician and representative notification and documentation of all actions taken as per policy. Additionally, change in transfer status as a result of the fall and adherence to any newly added intervention(s) as a result of a fall shall be addressed. III. As a means to ensure ongoing compliance with provision of implementation of fall interventions, re-evaluation of resident for transfer assistance, and the following of post fall procedures as per policy, the DON/designee shall be contacted immediately following any witnessed/unwitnessed fall. The DON/designee shall review nursing actions with the reporting nurse to confirm adherence with facility policy and implementation of any newly implemented intervention or change in transfer status- ensuring any revision is communicated to	

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	An activities of daily living tracking form, dated July 2018, indicated from 7/5/18 to 7/24/18 the resident was a limited assist of one person for transfers. On 7/25/18 to 7/28/18 the resident's transfer status changed to an extensive assist of two or more for transfers. A review of progress notes, dated 7/25/18 to 7/28/18, lacked documentation the resident's transfer status had changed or that the resident had not been acting herself. A fall investigation report, dated 7/29/18 at 1:45 p.m., indicated the resident had a fall and was found on her right side on the floor. The resident was noted to have attempted to change her clothes without assistance and slipped forward out of her wheelchair. The report lacked documentation vitals were obtained before transferring resident to the bed. A nursing summary, dated 7/29/18 with no time noted, indicated the resident was found on the floor on the right side of her face, with bright red blood noted on the floor. The resident sat up and a cut was noted to her right eyebrow and a small hematoma on the middle of her forehead, she grabbed at staff and was anxious. The resident was lifted onto the bed, and when calmed down vital signs were taken and neuro checks were completed. At the same time, another nurse called the physician and an order was obtained to send the resident to the emergency department to be evaluated and treated. A nurse's note, dated 7/29/18 at 2 p.m., indicated a noise was heard from the resident's room and resident was found on her right side on the floor. A laceration was noted to the right eyebrow from		oncoming staff. Should non-compliance be identified, immediate corrective and/or disciplinary action shall be taken. Additionally, documentation of all post fall actions shall be reviewed at each morning meeting following the fall/incident to confirm the following of policy and documenting of all actions taken and notifications made. Should non-compliance be identified, immediate corrective and/or disciplinary action shall be taken. The interdisciplinary team shall proceed to review any newly implemented intervention, review and revise the plan of care if indicated, and ensure any revisions made by the team are communicated to staff. Non-compliance and corrective actions shall be recorded for tracking purposes to identify patterns/trends and to conduct root cause analysis, in an effort to implement necessary performance improvement initiatives upon discovery. IV. As a means of quality assurance, aforementioned tracking, root cause analysis and any corrective actions taken as a result shall be reported by the DON to the Quality Assurance Committee on a quarterly basis and will continue ongoing until 100% compliance with adherence to facility policy is evident for no less than 6 months.	

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	hitting her glasses and a hematoma noted above that. Resident had complaint of pain to the right hip and right should, and was unable to assess range of motion due to the resident yelling in pain. Neuro checks (check for level of consciousness) were within normal limits and physician was called and gave order to send to emergency department for evaluation and treatment. Ambulance service was called and transported resident to the emergency room via gurney. A Physician's order, dated 7/29/18, indicated to send the resident to the emergency room for evaluation and treatment. A Physician's discharge summary, dated 7/29/18 at 2 p.m., indicated the resident had a history of falls and was admitted to the hospital post fall and final diagnoses were subdural hematoma and hip fracture with a fair prognosis. A hospital progress note, dated 7/29/18 at 7:02 p.m., indicated the resident suffered a fall that day. The resident appeared to be in pain with moaning and grasping at the time of arrival to the emergency department. A cat scan to the lower extremity revealed an acute right introchanteric (femur) to subtrochantric fracture, a cat scan to the head revealed right frontal temporal parietal subdural hematoma (a pool of blood between and its outermost covering) with mild leftward midline shift subfalcine herniation (displacement of the brain) with right temporal and posterior subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). At this same time, with the severity of the resident's condition the resident's family made the determination to make the resident comfort measures.		V. Correction Date: 11/23/18	

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	An Indiana State Department of Health Certificate of Death, dated 8/7/18, indicated the resident's date of death was 7/31/18 at 1:00 a.m. The immediate cause of death listed was subdural hematoma, and subarachnoid hemorrhage. A care plan, revised on 6/12/18, indicated the resident was at risk for falls due to gait disturbance related to weakness and was a limited assistance with walking. Interventions included but were not limited to: continue to monitor and follow proper fall precautions. During an interview, on 10/23/18 at 1:57 p.m., the Quality Improvement Manager indicated the resident was transferred to her bed after the fall on 7/29/18 and should not have been moved with a head injury and suspected fracture. When a head injury occurred, 911 should have been called because it was an emergency situation. Vital signs should have been obtained before transferring the resident to her bed, and no documentation was found to support they had been, only documentation they had been obtained after the resident was transferred. Interventions should be updated on the resident's care plan after each fall, and was not completed as it should have been. She indicated she was unaware the resident had a change in transfer status from 7/25/18 to 7/28/18 and that should have been reported as a change of condition for the resident and was not. The resident had been a limited assist of one with transfers. She indicated staff had indicated the resident had not been acting herself before her fall on 7/29/18, but no documentation of this change was found. On 10/24/18 at 10:00 a.m., the Quality Improvement Manager provided a document titled, "Charting," and indicated was a document currently being			

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	used by the facility for charting. The document indicated, "Charting: Changes in condition, always write a detailed nurses note describing a resident's change in condition, along with a description of the prudent actions you took...."2. Resident 43's record was reviewed on 10/22/18 at 10:14 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/9/18, indicated the resident was cognitively intact and had one fall with major injury since the prior assessment. Diagnoses on the resident's profile included, but were not limited to, presence of right artificial hip joint and history of falling. A return from therapy checklist, dated 7/5/18, indicated therapy recommended the resident be transferred to wheelchair or bedside commode with one staff assistance. A nursing summary, dated 7/11/18, indicated the resident required one staff assistance to transfer to the bedside commode. A Complete Metabolic Panel (CMP) (a blood test to check the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), dated 7/20/18, indicated a sodium (an electrolyte) level of 118, normal range 135-145. A physician's order, dated 7/20/18, indicated send the resident to the emergency room (ER) for evaluation and treatment if the resident had dizziness, confusion, or became unstable. A nurse's note, dated 7/22/18 at 4:45 a.m., indicated the resident was lowered to the floor by the aide during a transfer from the bedside commode to the bed. The resident reported she			

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	lost her balance. No evident injuries were noted. The resident complained of mild pain and soreness to the left hip and was assisted back to bed. The resident's blood pressure was 96/50, normal range 120/80-140/90. The physician was to be contacted for further instructions. The note lacked documentation the physician was contacted at that time. A nurse's note, dated 7/22/18, with no time documented, indicated the nurse was notified upon arrival the resident fell at 5:00 a.m. The resident was in pain. The previous charting stated the resident's blood pressure was low, but was normal at 148/78 when this nurse checked. The resident complained of left hip pain at an 8 out of 10, on the pain scale. The physician was contacted, and the resident was transferred to the ER. A nurse's note, dated 7/22/18 at 4:00 p.m., indicated the nurse spoke with hospital staff, and the resident was admitted with diagnoses of fractured left femur (thigh bone), hyponatremia (low sodium in the blood), and hypokalemia (low potassium in the blood). A physician notification form, dated 7/22/18 at 4:45 a.m., indicated the resident lost her balance during a transfer and fell to the floor with Certified Nursing Assistant (CNA) assistance. No evident injuries were noted. The resident complained of mild soreness to the left hip and was assisted back to bed. A follow up note, on the same form, on 7/22/18 at 12:30 p.m., indicated the resident was sent to the ER with diagnoses of fractured left femur, hyponatremia, and hypokalemia. A fall investigation report, dated 7/22/18, indicated the resident fell at 4:45 a.m. The			

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	resident's blood pressure was 96/50. Factors which contributed to the fall included medical status or physical condition, and abnormal or significant vital signs. The resident's blood pressure may have contributed to the fall. An x-ray, dated 7/22/18, indicated a subtle impaction fracture (an impacted fracture occurs when the broken ends of the bone are jammed together by the force of the injury) to the transcervical region (middle part of the femur neck) left femur. A nurse's note, dated 8/2/18, indicated the resident returned to the facility. A care plan, target date 11/30/18, indicated the resident had been cleared by therapy to transfer with two person assistance from wheelchair to bed and bedside commode. The resident used a gait belt and a front wheeled walker. A care plan, target date 11/30/18, indicated the resident was at risk for falls and had fallen on 7/22/18. During an interview, on 10/22/18 at 11:41 a.m., the Director of Nursing (DON) indicated the physician notification form was a form filled out and placed in the communication binder to be reviewed when the physician came into the facility for his next visit. It was acceptable for the staff to notify the physician by the form if the resident had not been injured. The staff should have paged the physician and spoken to him for any falls with injury. She thought they should not have moved the resident from the floor after the fall if she complained of pain. During an interview, on 10/22/18 at 2:11 p.m., the			

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	Quality Improvement Manager indicated she was unable to find any documentation to support the physician had been contacted before 12:30 p.m. on 7/22/18, to report the fall and the resident's complaints of pain. During an interview, on 10/23/18 at 9:54 a.m., the Care Plan Coordinator indicated the mobility care plan should not have indicated the resident required the assistance of two staff members for transfers. At the time of the fall, the resident required one staff member assistance with transfers, and the care plan should have been updated. During an interview on 10/23/18 at 10:57 a.m., the DON indicated the resident fell on 7/22/18 at 4:45 a.m. The night shift nurse called the DON between 6:00 a.m. and 6:30 a.m., and notified her of the fall. At that time, the DON advised the night shift nurse to tell the day shift nurse to contact the physician with the assessment. At that point, the nurse had not yet spoken to the physician. The day shift nurse had not notified the physician because when she went to the resident's room, the resident was asleep. Another nurse came in at 10:00 a.m. The resident complained of pain, and the 10:00 a.m. nurse notified the physician after the start of the shift. She was unable to find any documentation the physician was contacted before 12:30 p.m. on 7/22/18. On 10/19/18 at 1:45 p.m., the Care Plan Coordinator provided a document titled, "CAREPLANNING," and indicated it was the policy currently being used by the facility. The policy indicated, "...The care plan is a list of goals for meeting the resident's medical...needs and tells how those needs will be met...."			

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	On 10/23/18 at 11:37 a.m., the Quality Improvement Manager provided a document titled, "Fallen Resident: Witnessed or Unwitnessed," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To assess a Resident noted to have had a witnessed or unwitnessed fall for injuries and provide treatment, as indicated. POLICY: Upon observing a fall (witnessed), or finding a Resident who has fallen (unwitnessed), the Resident will be assessed for injuries and emergency care provided. PROCEDURE: ...8...The nurse shall assess for sign/symptoms of fracture, dislocation or head injury. 9. Assist Resident to chair or to bed as indicated using the appropriate mechanical lift...The licensed nurse will notify the physician and family of falling incident...." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an			

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	indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a medical justification was present for a Foley catheter (F/C) (a flexible tube drains urine from the bladder) (Resident 43), a catheter drainage bag was covered to maintain a resident's privacy (Resident 43), a care plan was developed for a Foley catheter (Resident 43), and Foley catheter tubing did not touch the floor (Residents 43 and 35) for 2 of 2 residents reviewed for catheters. Findings include: 1. On 10/17/18 at 2:05 p.m., Resident 43 was observed sitting up in her wheelchair, next to the bed. The Foley catheter drainage bag was hanging on the bed frame and the catheter tubing was lying on the floor, between the resident's wheelchair and the bed frame. On 10/18/18 at 1:13 p.m., the resident was observed sitting up in her wheelchair, next to the bed. The Foley catheter drainage bag was	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** I. 1-2 Resident #43's catheter has been removed. Resident #35 was not harmed as a result of staff's improper positioning of resident's catheter tubing and bag. II. As all residents with catheters could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with ensuring that the drainage bags and tubing of residents with in-dwelling catheters are positioned correctly, staff received in-service training on the facility policy for positioning of catheter bags and tubing and of the importance to ensure resident's catheter bags always have a dignity cover. Root cause analysis indicated that the catheter bags used by the facility	11/23/2018

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	155261	A. BUILDING 00 B. WING	10/24/2018

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	hanging on the bed frame and the catheter tubing was lying on the floor, between the resident's wheelchair and the bed frame. On 10/19/18 at 1:33 p.m., the resident was observed sitting up in her wheelchair, next to the bed. The Foley catheter drainage bag was hanging on the bed frame and the catheter tubing was lying on the floor, between the resident's wheelchair and the bed frame. On 10/19/18 at 2:20 p.m., the resident was observed walking in the hallway with the assistance of 2 staff members, and a rolling walker. The Foley catheter drainage bag was hanging on the front of the resident's walker, uncovered, and clearly visible. On 10/22/18 at 2:48 p.m., the resident was observed sitting up in her wheelchair, next to the bed. The Foley catheter drainage bag was hanging on the bed frame and the catheter tubing was lying on the floor, between the resident's wheelchair and the bed frame. Resident 43's record was reviewed on 10/22/18 at 10:14 a.m. A 5-day Minimum Data Set (MDS) assessment, dated 8/9/18, indicated the resident had an indwelling catheter. Diagnoses on the resident's profile included, but were not limited to, retention of urine unspecified. The diagnosis lacked documentation of documented post void residual (the amount of urine left in the bladder after going to the bathroom) over 200 milliliters (ml). A hospital documents review report, dated 7/22/18, indicated a secondary diagnosis acquired after admission was urinary retention. The		were larger than necessary and that the dignity bags also had some problems for appropriate use. The facility changed the catheter bags and dignity covers used. Following education provided, the DON/designee shall conduct random observations four times weekly on varied shifts to confirm compliance with facility policy. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	document lacked documentation of a post void residual over 200 ml. A nursing admission assessment, dated 8/2/18, indicated the resident was admitted with a Foley catheter. A nurse's note, dated 8/2/18, indicated the resident was re-admitted to the facility from the hospital with a Foley catheter related to mobility issues. The note lacked documentation of a medical justification for the continued use of the Foley catheter. A Catheterization Assessment, dated 8/30/18, indicated the appropriate rationale should have been checked. Appropriate rationales included, "Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: Documented post void residual volumes in a range over 200 milliliters (ml). Inability to manage the retention/incontinence with intermittent catheterization. Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction. Contamination of Stage III or IV pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence. Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain...." The assessment lacked documentation any of the rationales applied to the resident. A physician's order, dated 10/17/18, indicated remove Foley catheter in the morning, replace the catheter if the resident had not voided in 6 hours and leave the Foley catheter in place if greater than 250 ml of urine.			

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A nurse's note, dated 10/17/18, indicated received a new physician's order to remove the Foley catheter in the morning. If the resident had not voided in 6 hours, replace the Foley catheter if the post void residual was greater than 250 ml.

A nurse's note, dated 10/18/18, indicated the resident had refused to have the Foley catheter removed. The physician indicated to discontinue the removal of the Foley catheter and it would be addressed on his next clinical day. The nurse's notes lacked documentation of any previous physician contact or previous attempts to remove the Foley catheter prior to 10/17/18.

A physician's order, dated 1019/18, indicated catheter 16 french (fr) (size), 10 cubic centimeter (cc) balloon, change every month and as needed for patency (openness). The order lacked documentation of a medical justification for the use of the Foley catheter.

Current care plans lacked documentation a care plan for the Foley catheter was developed.

Physician's progress notes lacked documentation the physician addressed the Foley catheter prior to the physician's order on 10/17/18.

During an interview, on 10/23/18 at 9:54 a.m., the Care Plan Coordinator indicated the Foley catheter should have been care planned. She was unable to find a care plan for the Foley catheter in the resident's current care plan. She was not sure why it was missed.

During an interview, on 10/23/18 at 10:08 a.m., Licensed Practical Nurse (LPN) 9 indicated the Foley catheter tubing should not have been on

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the floor. Catheter drainage bags should have been covered by a dignity bag so they were not visible. She was told the Foley catheter was placed due to urinary retention, but she was not aware of any supporting documentation for the urinary retention. The Foley catheter was left in place because of the resident's immobility. The physician had ordered the Foley catheter discontinued on 10/17/18, but the resident refused to have it removed. The physician should have addressed the Foley catheter on his first visit after the resident's re-admission to the facility from the hospital.

During an interview, on 10/23/18 at 10:23 a.m., the Quality Improvement Manager indicated there was not a specific facility policy for Foley catheter tubing on the floor and drainage bags being covered. The Foley catheter tubing should not have been on the floor. The catheter drainage bag should have been covered by a dignity bag. Catheters should have been addressed at the time of the admission to the facility.

During an interview, on 10/23/18 at 11:37 a.m., the Quality Improvement Manager indicated the hospital documentation indicated a diagnosis of urinary retention. There was no documentation of a urologist consultation or post void residual to support the diagnosis of urinary retention.

During an interview, on 10/23/18 at 11:45 a.m., the Quality Improvement Manager reviewed the facility's policy for medical justification for the use of a catheter. She was unable to find documentation to support the medical justification for use of the Foley catheter as indicated as required in their facility policy.

On 10/19/18 at 1:45 p.m., the Care Plan Coordinator

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	provided a document titled, "CAREPLANNING," and indicated it was the policy currently being used by the facility. The policy indicated, "...The careplan is a list of goals for meeting the resident's medical...needs and tells how those needs will be met...." On 10/23/18 at 11:37 a.m., the Quality Improvement Manager provided a document titled, "CATHETERIZATION ASSESSMENT, COMPLETION OF: PURPOSE: Evaluation of the need for catheterization will ensure a Resident who enters the facility without an indwelling catheter will not be catheterized unless the Resident's clinical condition demonstrates that catheterization is necessary. POLICY: An indwelling catheter will only be used when there is a valid medical justification for use...and a corresponding physician order. PROCEDURE: STEP ACTION: 1. Upon receipt of a physician order for catheterization, or staff report of the potential need to obtain an order for Resident catheterization, the facility shall be expected to show evidence of any medical factor which mandates the intervention per completion of a Catheterization Assessment. Examples of clinical conditions...which demonstrate that catheterization is appropriate include: Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: Documented post void residual volumes in a range over 200 milliliters (ml). Inability to manage the retention/incontinence with intermittent catheterization. Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction. Contamination of Stage III or IV pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence. Terminal illness or severe impairment, which			

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	makes positioning or clothing changes uncomfortable, or which is associated with intractable pain. 2. The assessment will ensure medical justification for use is identified and said justification is affirmed by the physician...." 2. On 10/17/18 at 9:53 a.m., Resident 35 was observed in his room, sitting in a reclining chair. His catheter tubing was resting and curled on the floor. Dull yellow fluid with a thick white cloudy substance was observed in the tubing. On 10/17/18 at 1:41 p.m., Resident 35 was observed sitting up in his reclining chair, and a visitor was sitting next to him in a visitors chair. Resident 35's catheter bag was observed tied to the leg of the visitor chair but resting on the floor, and the catheter tubing was touching the floor. Dull yellow fluid was observed in the tubing. On 10/22/18 at 9:44 a.m., a brief medical record review was completed for Resident 35. The following documents were provided by the Quality Improvement Manager on 10/22/10 at 11:00 a.m. A most recent comprehensive assessments was a quarterly Minimum Data Set (MDS) assessment dated, 9/20/18. The MDS indicated Resident 35 used an indwelling catheter, and had active diagnosis to include but were not limited to: benign prostatic hyperplasia (enlarged prostate), chronic kidney disease, and diabetes. Current physician orders for Resident 35 included but were not limited to, orders for catheter care and maintenance. A current care plan for Resident 35 indicated, "... I [Resident 35] have a history of urinary infections...."			

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	3.1-41(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure an as needed (PRN) anti-anxiety medication was re-evaluated after 14 days of the physician's order start date and had parameters in place for the administration of an anti-anxiety medication for 1 of 5 resident's reviewed for unnecessary medications (Resident 8). Findings include: Resident 8's record was reviewed on 10/19/18 at 11:24 a.m. A physician's order, dated 8/24/18, indicated lorazepam (anti-anxiety) 2 milligrams (mg)/ milliliters (ml), give 0.25 ml to 0.5 ml under the tongue every 4 hours as needed for anxiety (intense, excessive, and persistent worry and fear) or seizures (a disorder in which nerve cell activity in the brain was disturbed). The order lacked parameters when to administer 0.25 ml or 0.5 ml. Diagnoses on the resident's profiled included, but were not limited to, anxiety disorder. The profile lacked documentation the resident had a diagnosis of seizures. A Psychotropic Medication Review, dated 10/9/18, indicated lorazepam 2 mg/ml to be	F 0758	**F758 Free from Unnecessary Psychotropic Meds/PRN Use** I. Resident #8's PRN psychotropic has been evaluated and clarified by the physician. II.1-3. In an effort to identify others who may have been affected, a review will be conducted of all residents receiving PRN psychotropic medications and appropriate timing of review, parameters, and continued justification for use. III. As a means to ensure ongoing compliance, the licensed nursing and pharmacy staff have received education regarding PRN psychotropic medication use and the need for appropriate duration of use and justification for use. Root cause analysis indicated that the facility end of life care/comfort care order set did not meet the requirements for psychotropic medication use. The facility's end of life care order set has been revised appropriately. At the time	11/23/2018

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	continued greater than 14 days due to end of life care. There was lack of documentation the medication was reviewed 14 days after the initial order date of 8/24/18. A Medication Administration Record (MAR), dated October 2018, indicated lorazepam had not been administered from 10/1/18 to 10/23/18. A MAR, dated September 2018, indicated lorazepam had been administered one time the month of September, on 9/1/18. During an interview, on 10/22/18 at 10:40 a.m., the Pharmacist indicated the resident's lorazepam order was not re-evaluated at 14 days and was not looked at until 10/9/18 because the resident was end of life care. The lorazepam dose was ordered as, give 0.25 ml to 0.5 ml and did not have specific parameters in place that indicated when to administer 0.25 ml and when to administer 0.5 ml. It was expected the nurse would start with the lowest dose and increase the dose if the lower dose was not effective. He also indicated he did not see where the resident had a diagnosis of seizures on the diagnosis list and that when a resident was on end of life care they were at risk for seizures. During an interview, on 10/22/18 at 11:24 a.m., the Administrator indicated they did not have a policy for PRN anti-anxiety medications but would follow the state regulations. The PRN anit-anxiety medication should have been re-evaluated at 14 days and a rationale documented from the physician for continued use and duration. She also indicated the medication should have indicated when to administer the 0.25 ml dose and when to administer the 0.5 ml dose, the order lacked parameters.		a PRN psychotropic medication is ordered, the pharmacist/designee shall review for appropriate justification, appropriate parameters, and appropriate duration of use. Should non-compliance be observed, continued communication with the physician or medical practitioner will occur. Monitoring for compliance will be completed by the DON or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Correction Date: 11/23/18	

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	3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures were maintained	F 0880	**F880 Infection Prevention and Control** I. The applicable caregiver was	11/23/2018

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	during a dressing change observation for 1 of 1 pressure ulcer dressing change observations (Resident 18). Findings include: During a dressing change observation of Resident 18, on 10/19/18 at 11:11 a.m., Licensed Practical Nurse (LPN) 12 washed her hands and applied gloves. She than cleansed the resident's coccyx with soap and water. At this time, she removed her gloves and applied new gloves without washing her hands in between. Silvasorb (antimircobial) gel was applied and the wound area was covered with allevyn (hydocellular dressing). During an interview, on 10/19/18 at 1:08 p.m. LPN 12 indicated she should have washed her hands after she was finished cleansing the resident's coccyx area and removed her gloves and before new gloves were applied. Resident 8's record was reviewed on 10/19/18 at 1:33 p.m. A physician's order, dated 8/9/18, indicated an order to apply silvasorb (antimircobial) gel to coccyx wound bed after cleansing and cover with allevyn. The resident had a stage 2 pressure ulcer (partial-thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) that was facility acquired. A care plan, revised on 8/29/18, indicated the resident had an open area to her coccyx and to cleanse with soap and water and apply silversorb to wound bed, cover with allevyn sacrum dressing. A significant change Minimum Data Set (MDS),		identified and re-educated as to the facility policy regarding handwashing and gloving. II. As all residents could be affected the following corrective action was taken; III. As a means to ensure ongoing compliance, nursing staff will be re-educated as to facility policy addressing handwashing, gloving and treatments. IV. As a means of quality assurance, following aforementioned training, the DON/designee shall conduct random observations of staff performing handwashing/gloving/treatments four times weekly on varied shifts to confirm compliance with facility policy. Should non-compliance be observed, corrective action shall be taken. Results of the observations shall be reported to the QA Committee on a quarterly basis and frequency increased or decreased on the basis of results until 100% compliance is exhibited. V. Correction Date: 11/23/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155261	A. BUILDING 00 B. WING	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	dated 9/6/18, indicated the resident had a stage 2 pressure ulcer, acquired on 8/7/18. On 10/19/18 at 12:06 p.m., the Administrator provided a document titled, "Handwashing Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...It is the policy of this facility that all staff will wash their hands effectively and appropriately to control the spread of infection...Policy for treatments: two gloves will be used for all treatments requiring both hands to come in contact with the resident. Hand washing will be done before gloving and after removing gloves...." 3.1-18(a)			