STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155441	A. BUILDING 00 B. WING	08/11/2017

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure survey. This visit was in conjunction with the Investigation of Complaint IN00237137. Complaint IN00237137 - Unsubstantiated due to lack of evidence Survey dates: August 7, 8, 9,10, and 11, 2017 Facility number: 000338 Provider Number: 155441 AIM number: 100287590 Census bed type: SNF/NF: 24 Total: 24 Census payor type: Medicaid: 21 Other: 3 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 16, 2017.	F 0000		

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

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F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct			

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	observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. Based on record review and interview, the facility failed to assess a resident by Speech Therapy who was experiencing frequent coughing and choking at meals for the correct diet consistency and the observations and documentation of a resident's skin assessment. This deficient practice affected 1 of 2 residents reviewed for dental status (Resident 18) and 1 of 3 residents reviewed for non-pressure related skin conditions. (Residents 19) Findings include: 1. Review of the clinical record for Resident 18 on 8/9/17 at 9:30 a.m. indicated the resident had diagnoses which included, but were not limited to, Huntington's disease, dementia, gastroesophageal reflux disease, and weakness. On 7/11/17, the Registered Dietitian documented the following note: "Per	F 0272	F272 Notice of Rights, Rules, Services, Charges - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o For Resident 19, Skin Assessment was completed, treatment orders obtained, and transcribed to treatment record o For resident 18 speech therapy screen was completed - how other residents having the potential to be affected by the same deficient practice will be identified and corrective action(s) will be taken; o Complete head to toe skin assessments will be completed by Director of Nursing and/or designee on all residents residing in the facility by 9/10/17 o Dietician recommendations for the preceding three months will be reviewed by the DON to ensure follow up action was taken - what measures will be put	09/10/2017

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	CDM (Certified Dietary Manager), he is coughing/choking at meals frequently. Recommend speech therapy to screen for the correct consistency." Documentation was lacking of this screening having been completed. On 8/10/17 at 1:00 p.m., the Administrator indicated "We have a Speech Therapist, but I guess somehow the resident fell through the cracks for some reason and the screening was not done per the referral on 7/11/17." A care plan dated 1/2/17 indicated "The resident has the potential for nutritional problem r/t [related to] mechanically altered diet...Monitor/document/report to MD PRN [as needed] for s/sx [signs/symptoms] of dysphagia: Pocketing, choking, coughing..." During an observation of the resident at lunch on 8/8/17 at 12:00 p.m. (Noon) indicated the resident had coughed on several occasions while eating his meal.		into place or what systemic changes will be made to ensure that the deficient practice does not recur; o weekly audits of skin assessments for completion and accuracy will be completed by DON and/or designee weekly for four weeks, monthly for six months and thereafter until compliance is maintained for two consecutive quarters. o DON and/or designee will review dietician recommendations with IDT during clinical meeting o Nurse education on procedure for processing/follow up of dietary recommendations by 9/10/17 - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed o September 10, 2017 - Facility requests desk review in lieu of revisit	

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F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and			

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	cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review			

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	assessments. Based on record review and interview, the facility failed to update a dialysis resident's care plan to include assessment of the shunt site and fluid restrictions. This deficient practice affected 1 of 1 dialysis resident reviewed. (Resident 33) Findings include: Review of the clinical record for Resident 33 on 8/10/17 at 9:00 a.m. indicated the resident had diagnoses which included, but were not limited to, end stage renal disease with hemodialysis. Review of the Interim Care Plan dated 7/17/17 indicated "Dialysis Treatment R/T [related to] End stage renal disease...Dialysis treatment 3 times per week as ordered; Schedule transportation services; Observe site for bleeding at shunt site; and Do not take blood pressure in left arm." The care plan interventions that were not checked included, but were not limited to, "Assess shunt site before and after dialysis and Fluid restrictions_____cc/day [cubic centimeters]." On 7/28/17, the dialysis center recommended the resident to be on, 1200 ml (milliliters) fluid restriction.	F 0280	F280 Right to Participate Planning Care - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o care plan was updated for resident #33 to reflect dialysis care. Clarification of recommendation for fluid restriction was reviewed, and determined that resident does not require fluid restrictions at this time. - how other residents having the potential to be affected by the same deficient practice will be identified and corrective action(s) will be taken; o Review of current resident's comprehensive care plans for completion and accuracy by MDS Coordinator and/or DON by 9/10/17 - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o The DON and/or designee will review the progress notes and recommendations made by practitioners when a Resident returns from receiving care and treatment from an offsite source after each occurrence for the next six months. o Nurse education on procedure for follow up of recommendations / orders from practitioners by 9/10/17	09/10/2017

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	During an interview with the Director of Nursing on 8/11/17 at 8:30 a.m., she indicated "Usually the MDS [Minimum Data Set] person takes care of all the changes and updates to the care plans but we are currently without one right now." On 8/10/17 at 1:25 p.m., the Administrator presented a copy of the facility's current policy titled "Resident Hydration and Prevention of Dehydration". Review of this policy at this time included, but was not limited to: "Policy Interpretation and Implementation:...13....Interdisciplinary team will update care plan and document resident response to intervention until team agrees that fluid intake and relating factors are resolved." 3.1-35(d)(2)(B)		- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in			

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	accordance with each resident's written plan of care. Based on record review and interview, the facility failed to obtain a Speech Therapy evaluation to determine correct diet consistency on a resident with coughing/choking episodes (Resident 18). The facility also failed to obtain weekly weights per MD order to evaluate edema. (Resident 10). The facility also failed to follow physician's orders and policy and procedure by failing to obtain measurements of bruising when performing skin assessments on Resident 3. Findings include: 1. Review of the clinical record for Resident 18 on 8/9/17 at 9:30 a.m., indicated the resident had diagnoses which included, but were not limited to, Huntington's disease, dementia, gastroesophageal reflux disease, and weakness. On 8/7/17, the following nursing note was documented "Follow up note: Consult note r/t [related to] nurse reports resident is having difficulty chewing/swallowing. Nurse reports having to thicken liquids past the thickness of NTL [Nectar Thick Liquid]. Rec [Recommend] diet change to puree	F 0282	F282 Services by Qualified Persons/Care Plan - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o Speech Therapy evaluation was completed for resident #18 on 8/12/17; Weight was obtained for resident #10; skin assessment and wound measurements completed for resident #3 - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o Complete head to toe skin assessments will be completed by Director of Nursing and/or designee on all residents residing in the facility by 9/10/17 o DON and/or designee will review physician orders for weights for all residents in the facility. Weights will be measured for all residents residing in the facility by 9/10/17 o DON and/or designee will review current residents for need for therapy screen/evaluation by 9/10/17 - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o Staff education regarding importance of obtaining resident	09/10/2017

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	HTL [Honey Thick Liquid] and have ST [Speech Therapy] consult." In an interview on 8/10/17 at 1:00 p.m., the Administrator indicated "We have a Speech Therapist but she is on vacation right now and the company is looking for a Speech Therapist to cover in the meantime." No Speech Therapy evaluation had been completed as of 8/11/17. A care plan dated 1/2/17 indicated "The resident has the potential for nutritional problem r/t mechanically altered diet...Monitor/document/report to MD PRN [as needed] for s/sx [signs/symptoms] of dysphagia: Pocketing, choking, coughing..." Observation of resident at lunch on 8/8/17 at 12:00 p.m. indicated the resident had coughed on several occasions while eating his meal. 2. Review of the clinical record for Resident 10 on 8/8/17 at 1:30 p.m. indicated the resident had diagnoses which included, but were not limited to, hypertension, cardiomegly, peripheral vascular disease, and heart failure. On 9/25/15, the physician wrote an order for "Weekly weights on Monday to		weights and follow through with therapy as ordered will be completed by 9/10/17 o Staff education regarding importance of complete and accurate skin assessments, including wound measurements, will be completed by 9/10/17 o DON and/or designee will review weekly weight documentation for completion, weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. o DON and/or designee will review new orders and recommendations, including therapy orders, with IDT, during daily clinical meetings, and audit follow up weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	

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	monitor edema - notify MD if more than 2 # [pounds] in 24 hours or 5# in a week gained." Review of the weekly weights failed to note weights being obtained on the following dates: 4/10, 4/17, 6/1, 6/10, 7/1, 7/25, and 7/27/17. In an interview with LPN 1 on 8/10/17 at 10:00 a.m., she was unable to say why the weights were not obtained		- by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:			

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	(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to notify the resident's physician of a new order for Fluid Restrictions per dialysis center, implement the fluid restriction order from dialysis center, complete post assessments on the resident after dialysis, and monitor the shunt site every shift for 1 of 1 dialysis resident reviewed. (Resident 33). Findings include: Review of the clinical record for Resident 33 on 8/9/17 at 1:00 p.m. indicated the resident had diagnoses which included, but were not limited to, end stage renal disease with hemodialysis. On 7/28/17, The Dialysis Center sent a "Dialysis Nutrition Communication Fax" The fax indicated to ":...Please monitor fluid intake closely and ensure liquids are	F 0309	F309 Provide Care/Services for highest well being - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o Clarification of recommendation for fluid restriction received from dialysis 8/14/17, resident does not require fluid restrictions at this time and physician notified. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o No additional dialysis residents reside in facility at this time - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o Nurse education on the importance of complete and	09/10/2017

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	divided appropriately for medications and meals. Recommended diet order...1200 ml [milliliters] fluid restriction." Documentation was lacking of the order having been implemented. 1. During an interview on 8/9/17 at 1:50 p.m., the resident indicated "Dialysis spoke to me about fluid restriction. I can have three cups of water a day plus I drink Ensure [a nutritional supplement] too and a shake for breakfast. They put apple juice on my tray. I don't drink that much, but will drink the ensure if I don't eat." In an interview on 8/9/17 at 2:00 p.m., the Dietary Manager indicated she was not aware of the resident being on fluid restrictions. "I even checked my tickets to be sure and no order was written" and "I just spoke with nursing who said the resident is non-compliant and is drinking on her own." On 8/9/17 at 2:20 p.m., the Dietary Manager indicated "Nursing is calling the MD to get an official order for the fluid restrictions." Record review on 8/10/17 at 10:50 a.m. and 8/11/17 at 10:00 a.m. indicated the chart lacked documentation by nursing of having notified the MD (Medical Doctor)		accurate dialysis assessments and communication of recommendations to resident physician will be completed by 9/10/17 o DON and/or designee will review dialysis assessment, for all residents receiving dialysis treatment, weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the 1200 ml fluid restriction recommendation by dialysis. 2. Nursing notes indicated the resident had a fistula (surgically made passage) in her upper left arm and went to dialysis on Monday, Wednesday, and Friday mornings. Review of the Dialysis Assessments indicated they were completed prior to going to dialysis but not upon return on the following dailaysis days: 7/17, 7/21, 7/26, 7/28, 7/31, 8/21, and 8/7/17. During an interview on 8/11/17 at 8:35 a.m., LPN (Licensed Practical Nurse) 2 indicated "We do pre and post vitals checks when the resident gets back from dialysis. We also monitor for bleeding and check thrill and bruit. It all gets documented on the Dialysis Assessment form." No assessment of the shunt site for thrill/bruit could be located on the Dialysis Assessment form nor in the clinical record nursing notes. Review of the Interim Care Plan dated 7/17/17 indicated "Dialysis Treatment R/T [related to] end stage renal disease...Observe for bleeding at shunt site." On 8/9/17 at 2:03 p.m., the Administrator			

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	155441	A. BUILDING 00 B. WING	08/11/2017

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	presented a copy of the facility's current policy "Dialysis, Renal." Review of this policy at this time included, but was not limited to, "...The resident's Vascular Access will be routinely monitored for swelling, redness, pain, warmth, and/or drainage to identify potential complications. Physician will be notified as indicated. Residents with an AV fistula will have the site checked every shift for bruit and thrill - notify the primary care physician immediately of negative findings...Physician will be notified of any new orders obtained from the Dialysis Center for approval." On 8/10/17 at 1:25 p.m., the Administrator presented a copy of the facility's current policy titled "Resident Hydration and Prevention of Dehydration". Review of this policy at this time included, but was not limited to, "...Physician orders to limit fluids will take priority over calculated fluid needs. The Dietitian may refer calculated needs to the physician if restrictions potentially increase risk for dehydration...The dietitian will include resident preferences in distribution of allowed fluid...The Dietitian will educate the resident and family regarding fluid restriction...Nursing will monitor and document fluid intake and the Dietitian will be kept informed of status. ..."			

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	3.1-37(a)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview, and record review, the facility failed to follow	F 0371	F 371 Food Procure, store, prepare, and serve	09/10/2017

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	appropriate food storage guidelines for 2 of 2 kitchen observations and handwashing or hand sanitizer during contact with food and residents during 2 of 2 lunch meal services for 5 of 11 Residents in the Main Dining Room. (Residents 11, 2, 14, 28, and 19). This deficient practice had the potential to affect 24 of 24 residents currently residing in the facility Findings include: 1. During the initial observation of the kitchen on 8/7/17 at 6:20 p.m. while accompanied by the Cook, the following was observed: a. 1 bag of fish patties open to the air in the freezer. b. a bag of turkey slices in the refrigerator which had an open date 8/2/17. c. 1 large pot on the shelf above the range top covered in foil heavily soiled with tan debris on top and around he sides of pot. The Cook indicated "I have no idea what is in that pot covered in foil and why it is there." 2. During a kitchen observation on 8/8/17 at 11:45 a.m. while accompanied by the Cook, the following was observed: a. the pot on the shelf above the stove remained which was dusty to the touch on the sides and the foil covering the top.		- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o The bag of fish patties and the bag of turkey slices were disposed of immediately when called to the attention of the staff o The foil covered pot above the stove top was removed and sanitized o The wall vent above the refrigerator and the pipe in front were cleaned by maintenance o As soon as hand sanitation was called to the attention of the facility, staff were instructed on proper handwashing and sanitary handling of food and implements - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o The bag of fish patties and the bag of turkey slices were disposed of immediately when called to the attention of the staff o The foil covered pot above the stove top was removed and sanitized o The wall vent above the refrigerator and the pipe in front were cleaned by maintenance o As soon as hand sanitation was called to the attention of the facility, staff were instructed on proper handwashing and sanitary handling of food and implements	

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	A tray of garlic bread was observed below this shelf. b. the wall vent above the refrigerator was heavily soiled with gray/black dust and the pipe in front of unit was also heavily soiled with the black greasy dust. On 8/10/17 at 12:35 p.m., the Maintenance Director indicated "I clean the vents once a month and it was last cleaned the beginning of last month." At 1:00 p.m., the Maintenance Director verified the vent and pipe were heavily soiled and would need replacing. On 8/10/17 at 1:40 p.m., the Cook indicated "We have a 3 day left over policy. After 3 days it is disposed of unless it already has a date on it like milk or macaroni salad."		- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o A daily, weekly, and monthly kitchen sanitation schedule was updated by the FSS and all staff were in serviced on 8/25/17 o All food service workers were in serviced on 8/30/17 regarding food handling and storage, including storage and use of leftovers. o The FSS will monitor food handling and storage during daily rounds, at alternating meal times weekly for four weeks and bi-monthly for six months thereafter until compliance is maintained for two consecutive quarters. o The FSS or designee will check schedule for completion on a weekly basis for four weeks and bi-monthly for six months thereafter until compliance is maintained for two consecutive quarters. o All staff were in serviced on 8/25/17 regarding hand washing and sanitary food handling during meal service. The DON or designee will monitor meal service daily at alternating meals for four weeks and bi-monthly for six months thereafter until compliance is maintained for two consecutive quarters - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will	

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			be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	
F 0425 SS=D Bldg. 00	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; Based on observation, interview, and record review, the facility failed to ensure medications were delivered to the facility for daily administration related to inhalers for 1 of 5 residents reviewed for	F 0425	F 425 Pharmaceutical SVC-Accurate Procedures - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	09/10/2017

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	medication administration. (Resident 5) Findings include: During an observation of medication administration on 08/09/17 at 9:35 a.m., LPN (Licensed Practical Nurse) 1 indicated Resident 5 was out of his Breo inhaler since the weekend. when it ran out. She placed an order for the medication when it ran out. During an interview on 08/09/17 at 9:40 a.m., LPN 1 indicated "It takes 2-4 hours for the pharmacy to deliver medications to the facility." On 08/09/17 at 9:43 a.m., the Administrator provided a copy of the Medication Administration Record for Resident 5 which indicated on 08/08/17 and 08/09/17 the resident did not receive his prescribed Breo inhaler. During an interview on 08/09/17 at 9:48 a.m., LPN 1 indicated she just contacted the pharmacy and the medication was out of stock, which was why the inhaler was not delivered. "The pharmacy would deliver tonight. The medication would be administered tomorrow morning." The resident had not received the medication since 08/07/17.		o For resident #5 pharmacy was notified and medication was received - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o DON and/or designee will review all active orders for residents residing in facility and verify medications are available for administration as ordered, by 9/10/17. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o Nurse education on medication administration, policy for unavailable/refusal medication documentation will be completed by 9/10/17 o DON and/or designee will complete random audit of medication orders against MAR and medication cart, to ensure availability and accuracy of orders, weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	

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	The review on 08/09/17 at 10:15 a.m. of the MDS (Minimum Data Set) Quarterly review assessment, dated 07/26/17, indicated a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact). The Active Diagnosis indicated peripheral vascular disease, hypertension, hyperlipidemia, dementia, seizure disorder, depression, and chronic obstructive pulmonary disease. On 08/09/17 at 10:23 a.m., the review of the Admission Diagnosis indicated, but was not limited to, chronic obstructive pulmonary disease. The review on 08/11/17 at 11:02 a.m. of the resident's Progress Notes indicated no signs or symptoms of respiratory distress from not receiving the inhaler. On 08/11/17 at 11:02 a.m., the review of the Physician's Orders indicated, but was not limited to, "Breo Ellipta 200-25 MCG [microgram] 30 Dose Inhale 1 Blst [blast] W/Dev [with device] Orally once a Day COPD [chronic obstructive pulmonary disease] *Rinse mouth with Water after use--Do not Swallow." During an interview on 08/11/17 at 8:33 a.m. the DON (Director of Nursing) indicated when ordering medications the nurse should have continued to contact		o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	

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	the pharmacy until the needed medication was sent. The EDK (Emergency Drug Kit) could be used and staff had access to a stat (emergency) pharmacy. The medication could have been there in three hours. The nurse should circle their initials on the MAR (Medication Administration Record) if the medication was out and could not be administered. On 08/09/17 at 10:35 a.m., the Administrator provided a copy of the facility policy for Medication Shortages/Unavailable Medications which indicated, but was not limited to, "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain mediation from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take the action...If a medication shortage is discovered during normal Pharmacy hours...If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose...If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an			

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	emergency delivery...If a medication shortage is discovered after normal Pharmacy hours...If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action...Emergency delivery; or, ...Use of an emergency (back-up) Third Party Pharmacy...If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions...If the medication is unavailable from Pharmacy or a Third Party Pharmacy, and cannot be supplied from the manufacturer, Facility should obtain alternate Physician/Prescriber orders, as necessary..." 3.1-25(a) 3.1-25(g)(3)			
F 0431 SS=D Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general			

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	supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in			

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	Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications expiration dates were monitored for 1 of 2 medication carts reviewed. (Resident 22) Findings include: 1. On 08/08/17 at 2:08 p.m., the review of the Medication Carts indicated the following: Resident 22's carbidopa-levodopa (medication to treat Parkinson's disease) expired on 07/31/17. The review on 08/10/17 at 1:44 p.m. of the Admission Record for Resident 22 indicated, but was not limited to, a diagnosis of Parkinson's disease, schizophrenia, and schizoaffective disorder. The review of Resident 22's Physician's Orders on 08/10/17 at 1:56 p.m. indicated, but was not limited to, "Carbi-Levo [carbidopa-levodopa] 25-100 Tab [tablet] Give 1 Tablet By	F 0431	F 431 Drug Records, Label/Store Drugs and Biologicals - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o For resident #22, expired medication was removed from medication cart, MD was notified of incident, order obtained to dispose of medication and monitor resident per usual routine. Pharmacy notified and medication received. o For resident #5, pharmacy was notified of need for inhaler and medication was received. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o Medication cart audit will be completed by DON and/or designee to ensure all current residents have needed medications and not expired, by 9/10/17 - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff education regarding procedure	09/10/2017

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	Mouth 4 Times A Day For Parkinson's." On 08/08/17 at 2:36 p.m. the DON provided copies of the August, 2017 Medication Records for the Resident 22, which indicated, by the nurse's initials, the administration of the expired carbidopa-levodopa 4 times daily from 08/01/17 to 08/08/17, equaling 24 administrations. The review on 08/10/17 at 2:03 p.m. of the Nurse's Notes, dated 08/08/17 at 4:00 p.m. indicated "During cart audit, medication Carbidopa-Levodopa noted to have expired on 7-31-17. Res has rec'd [received] med [medication] QID [4 times daily] per order since then. MD [physician] notified & states medication would lose efficacy but no other ASE [associated side effects] would occur, & ordered disposal of medication, & cont [continue] to monitor res [resident] per usual routine. Med pulled from cart. Staff reminded to monitor expiration dates on medications." No documentation of adverse side effects from the expired medication was indicated. On 08/09/17 at 10:04 a.m. the Administrator provided a copy of the LTC [Long Term Care] FACILITY PHARMACY SERVICES AND PROCEDURES MANUAL which		for obtaining medications from pharmacy and communication to provider regarding unavailable and/or expired medications to be completed by 9/10/17 o DON and/or designee will audit medication administration records weekly for four weeks and monthly thereafter for six months until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed o September 10, 2017 - Facility requests desk review in lieu of revisit	

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	indicated, but was not limited to, "... Dispensing Errors...Expired medication error: Dispensing to the resident a medication that expires prior to administration..." 3.1-25(o) 3.1-(25)(k)(6)			
F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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;			

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	(ii) When and to whom possible incidents of 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and	F 0441	F 441 Infection Control, Prevent	09/10/2017

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	record review, the facility failed to follow appropriate infection control practices related to hand washing/glove use for the administration of medications for 4 of 5 resident reviewed for medication administration (Resident 19, 5, 15, 12), perineal care for 1 of 2 residents observed during care (Resident 20) and the administration of the second step tuberculosis screening for (Residents 29, 30, 32, and 33). Findings include: 1. On 08/09/17 at 8:42 a.m., LPN (Licensed Practical Nurse) 1 patted Resident 12 on the shoulder and pulled his wheelchair back before administering medication to Resident 19. No handwashing was performed before or after the administration of medication to Resident 19. 2. On 08/09/17 at 8:53 a.m., LPN 1 then entered the Main Dining Room to obtain the blood pressure of Resident 5 and administer his medication. No handwashing was performed before obtaining the blood pressure or before his medication was prepared and administered. 3. On 08/09/17 at 9:11 a.m., LPN 1 prepared the medication for		Spread - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o Residents #29, 30, 32, 33 were given 2 step PPD skin tests. o Resident #12, 19, 5, 15 were monitored for signs and symptoms of infection after the deficient practice occurred. o Regarding resident #20, all CNAs will be educated on 8/25/17 for proper Perineal Care per facility policy and procedure. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents residing in facility have potential to be affected by deficient practice. All resident's clinical records will be reviewed for administration of TB skin tests. Those residents who did not received a completed 2-step PPD will be given 2 step PPD skin tests. o all CNAs will be educated on 8/25/17 for proper Perineal Care per facility policy and procedure. o All residents residing in the facility will be observed for s/sx of infection r/t deficient practice. - what measures will be put into place or what systemic changes will be made to ensure that the	

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	administration to Resident 15 with no prior handwashing. The tablets were popped from packaging into her hands and placed into a medication cup. She applied gloves to administer the eye drops and medications. Upon entering the resident's room no handwashing or hand sanitizer was observed to be used prior to or after administration. 4. On 08/09/17 at 11:44 a.m., an accu check (blood sugar reading) was performed by LPN 1 on Resident 12 in the Main Dining Room. She applied gloves and gathered supplies with no prior handwashing. She removed her gloves and drew up the insulin. The LPN applied clean gloves and placed the trash into the medication cart receptacle, touching other trash. With the same gloves the insulin was administered to the resident in the dining room. She removed the gloves and then applied hand sanitizer. During an interview on 08/11/17 at 8:33 a.m., the DON (Director of Nursing) indicated the staff should wash their hands before medication administration and use hand sanitizer after medication administration. The nurse should wash their hands after touching trash and after insulin administration. The nurse should pop the medications into the cup and not		deficient practice does not recur; o All Staff education on infection control, including handwashing to be completed on 8/25/17. o All licensed staff in-serviced on 8/25/17 regarding timeliness and administration of Tuberculin 2-step PPD. o All nursing personnel in serviced on perineal care per facility policy and procedure on 8/25/17 o DON and or designee will observe perineal care weekly x 4 weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. o DON or designee will observe hand washing and glove use daily for four weeks and bi-monthly for six months until compliance is maintained for two consecutive quarter. o skin test and random audits of current residents for annual PPD compliance weekly x 4 weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented.	

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	into their bare hand.		Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	
F 0458 SS=B Bldg. 00	483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation and interview, the facility failed to ensure a room with more than two residents had at least 80 square feet per resident for 2 of 2 rooms capable of holding more than two residents. This affected Rooms 7 and 11 for 6 of 32 residents residing in the facility. Findings include: On 8/8/17 at 2:00 p.m. during an environmental tour, the Maintenance Director measured the square footage of Room 11 and room 7 at 234 square feet, indicating 78 square feet for each of the three residents residing in room 11, and room 7. The following was observed:	F 0458	F 458 Bedrooms Measure at least 80 SQ FT/Resident - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o A room waiver was requested for rooms 7 and 11. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o Only rooms 7 and 11 were effected, so no other residents were effected o Square footage of the room in no way poses a threat to the resident's health and safety o Square footage of room in no way poses a threat to the resident's	09/10/2017

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	*Room 7, SNF/NF (Skilled Nursing Facility/ Nursing Facility), had the capacity of three resident beds and was a total of 234 square feet, equaling 78 square feet per resident. *Room 11, SNF/NF, had the capacity of three resident beds and was a total of 234 square feet, equaling 78 square feet per resident. On 8/8/17 at 2:00 p.m. during an interview with the Administrator, he indicated that he did want to continue the room waiver for Room 11 and Room 7. 3.1-19(l)(2)(A) 3.1-19(l)(3) 3.1-19(l)(8)		quality of care and quality of life - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o Occupants of the rooms are notified of the room waiver and the rooms' dimensions are available upon request. Room waivers will be requested annually. The administrator is responsible for adhering to the requirements of the room waiver. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The administrator is responsible for oversite and practical application of policies and procedures governing room waivers. Any variance to the policies and procedures governing room waivers will be brought to the QAPI committee for review. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. o Obtaining the waiver from ISDH will show compliance in this area and will be obtained annually. - by what date the systemic changes will be completed. o September 10, 2017	

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			- Facility requests desk review in lieu of revisit	
F 9999 Bldg. 00	(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For healthcare workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first	F 9999	F 9999 Final Observation - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; o The housekeeping manager, C.N.A., and activity person were administered the 1st step PPD and will receive the 2ndstep as scheduled. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential of being affected by the deficient practice. All employee files will be reviewed by the human resource manager to ensure employees have received the PPD test, (or other screen, e.g. chest x-ray), and that all employees are current. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o A tracking process has been put in place to ensure new employees receive the 2-step TB test upon hire and annually thereafter. The administrator will monitor by	09/10/2017

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	step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This rule is not met as evidenced by: Based on record review and interview the facility failed to ensure employees received their annual and second step tuberculin skin testing for 3 of 10 employees reviewed. Findings include: Employee records were reviewed on 8/11/17 at 9:00 a.m. The "Employee TB Screening Tool" form for the Housekeeping Manager was provided on 08/11/17 at 9:00 a.m. The form indicated the Housekeeping Manager lacked the annual tuberculin skin test for 2017. The "Employee TB Screening Tool" form for CNA (Certified Nurse Aide) 3 was provided on 08/11/17 at 9:00 a.m. and was reviewed at that time. The form lacked CNA 3's annual tuberculin skin test for 2017. The "Employee TB Screening Tool" form		reviewing the PPD tracker weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; o The results of these audits will be reviewed by the QAPI committee monthly. If compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. - by what date the systemic changes will be completed. o September 10, 2017 - Facility requests desk review in lieu of revisit	

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	for Activity Assistant 2 was provided on 08/11/17 at 9:00 a.m. and was reviewed at that time. The form lacked a second step tuberculin skin test. On 8/11/17 at 9:05 a.m., the BOM (Business Office Manager) indicated, "We have been out of the tuberculin skin test solution for awhile now. It has been ordered three times including yesterday. The Executive Director has called and has been trying to get it." On 8/11/17 at 9:40 a.m., the Executive Director indicated, "We were able to give first step tuberculin skin tests but not second. We had to throw away our tuberculin solution since it was expired and have been trying to get some since. Pharmacy has it on back order. We were going to try to borrow some from another facility but have not gotten the chance to call." On 8/11/17 at 9:59 a.m., the Executive Director provided a copy of Human Resources Policies and Procedures Manual for Employment Tuberculosis, Screening Employees. The policy indicated, but was not limited to, "...Each employee will be screened for tuberculosis infection and disease...A physical examination shall be required for each employee of a facility within (1)			

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	month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method...ii. The tuberculin skin test must be read prior to the employee starting work. iii. For employees who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. Serial Testing..."The facility will conduct an annual tuberculin skin test on all employees and nonpaid personnel with a history of negative results."			