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	11/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00245125. Complaint IN00245125 - Substantiated. Federal/State deficiencies related to the allegations are cited at F353. Survey dates: November 14, 15, 16, 17, 20, 21, and 22, 2017 Facility number: 000162 Provider number: 155261 AIM number: 100284300 Census bed type: SNF/NF: 45 Total: 45 Census payor source: Medicare: 1 Medicaid: 38 Other: 6 Total: 45 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completd on December 4, 2017.	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.	

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

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	11/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0156 SS=D Bldg. 00	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as			

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	11/22/2017

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

(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
	the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and			

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	11/22/2017

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

(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
	Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency			

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	11/22/2017

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

(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
	concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the			

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	11/22/2017

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

(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
	nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the			

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	11/22/2017

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

(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
	resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review the facility failed to properly notify residents and family members of the effective end date for Medicare coverage related to skilled nursing services for 3 of 3 residents reviewed for notification of coverage ending. (Residents 4, 9, and 62) Findings include: On 11/22/17 at 10:05 a.m., a record review was conducted for residents who received notices of Medicare Non-Coverage for Services (NOMNC). Three notices, of random selection, were provided by the Administrator. These notices included Residents 4, 9 and 62. A document titled, "Notice of Medicare Non-Coverage", was provided for	F 0156	I. Please note that residents #4, #9, and #62 were not negatively affected as a result of the failure to mail a copy of the Notice of Medicare Non-Coverage. II. As all residents whose stays are covered by Medicare could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with notifying residents of their Medicare non-coverage, the Administrator will conduct weekly checks with therapy and/or the Social Services Director to ensure timely completion of notices and subsequent mailing of a copy 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 her designee. IV. As a mean of quality	12/21/2017

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	11/22/2017

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

(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
	Resident 4. This document indicated, the effective date coverage of skilled nursing services would end on 6/1/17. A hand written note, at the bottom of the page, signed by the Social Service Director (SSD) indicated, she left a phone message for the resident's (named) representative on 5/31/17. The representative returned the call and "understands". Resident 4 was notified, verbally, on 6/1/17. She read the form in the SSD office. There was not a signature, of patient or representative, on the document. The file did not contain a mailed notification. A document titled, "Notice of Medicare Non-Coverage", was provided for Resident 9. This document indicated, the effective date coverage of skilled nursing services would end on 6/1/17. A hand written note, at the bottom of the page, signed by the SSD indicated, on 6/12/17, a (named) representative was notified, she requested the resident be discharged with in home services. There was not a signature, of patient or representative, on the document. The file did not contain a mailed notification. A document titled, "Notice of Medicare Non-Coverage", was provided for Resident 62. This document indicated, the effective date coverage of skilled		assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the monitoring is provided in Attachment A. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F156.	

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	11/22/2017

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

(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
	nursing services would end on 6/1/17. The notification was not signed by the resident or family member. A hand written note at the bottom of the page, signed by the SSD indicated, on 7/3/17 she called and spoke with Resident 62's (named) representative. He did not wish to appeal. There was not a signature, of patient or representative, on the document. The file did not contain a mailed notification. During an interview with the SSD, on 11/22/17 at 10:57 a.m., she indicated, therapy notified her before services ran out. She tried to notify them (residents and/ or representatives) as soon as possible. She thought they were suppose to be given a 48 hour notice. She had not read or seen a policy, but assumed they followed the Medicare guidelines. She had never mailed out a notification to a family member or resident representative. She called on the phone, informed them, and wrote a note on the document. On 11/22/17 at 1:32 p.m., during an interview, the Administrator indicated, the facility did not have a policy for notification of Medicare non-coverage, or liability notification, they followed the Medicare guidelines. She provided a document, she identified as the Medicare guideline.			

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	11/22/2017

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

(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
	The document titled, "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC)", indicated, providers were required to develop procedures to use when the beneficiary/enrollee was incapable or incompetent, and the provider cannot obtain the signature the enrollee's representative through direct personal contact. If the provider was personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services were no longer covered. The date of the conversation was the date of the receipt of notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact could not be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signed (or refused to sign) the receipt is the date of receipt. A dated copy of the notice should be placed in the enrollee's file. 3.1-4(f)(3)			

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	11/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

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	11/22/2017

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

(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
	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview, the facility failed to ensure the physician and family were notified of a resident's significant weight loss for 1 of 3 residents reviewed for nutrition (Resident 10). Findings include: Resident 10's record was reviewed on 11/22/17 at 9:30 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/2/17, indicated Resident 10 was severely cognitively impaired. A diagnosis list in the admission record included, but was not limited to, diagnoses of gastro-esophageal reflux disease (GERD), hyperlipidemia, and dementia. The weight flow sheet indicated: a. 10/8/17, 92 pounds. b. 10/22/17, 89.4 pounds. c. 11/5/17, 86.6 pounds.	F 0157	I. Resident 10's family and physician have been addressed as to resident's weight loss. II. In an effort to identify others who may have been affected in regard to notification of significant weight change, all resident weights obtained within the last 30 days will be reviewed for appropriate resident/legal representative and physician notification. Should concern with notification be identified, necessary notification will be made and documented. III. As a means to ensure ongoing compliance, licensed nursing staff shall receive in-service training in regard to resident weights and subsequent notification of the dietary manager, physician, and resident responsible or interested party. IV. As a means of quality assurance, residents' weights will be reviewed twice monthly by the Director of Nursing or her designee to confirm notifications of significant weight loss or gain were made and documented. Should non-compliance be	12/21/2017

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	11/22/2017

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

(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
	A significant weight changes sheet was provided by the MDS coordinator on 11/22/17 at 10:34 a.m. The weight changes sheet indicated that Resident 10's weight loss was a 5 percent weight loss. There was no documentation of physician or family notification of the weight loss on the weight flow sheet. A care plan, initiated 5/27/15, indicated Resident 10 was confused related to dementia. Her appetite had improved since admission, and her weight was stable. She would benefit from ongoing nutritional monitoring. Interventions included, but were not limited to, obtained weight every 2 weeks and observed for changes and reviewed weight with the physician during routine visits, and if there was a weight loss of 5 percent in 30 days or 10 percent in 90 days the physician would be notified sooner. Nurse's notes from 9/27/17 through 11/22/17 were reviewed, and no documentation of physician or family notification of the weight loss was observed. During an interview on 11/22/17 at 10:46 a.m., the Director of Nursing (DON)		observed, corrective action shall be taken, including re-education and/or disciplinary action, as warranted. Results of monitoring and action taken will be discussed during quarterly Quality Assurance meetings. V. Evidence of the in-servicing is provided in Attachment B. Evidence of the monitoring is provided in Attachment C. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F157.	

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	11/22/2017

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

(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
	indicated a significant weight loss was 5 percent in 30 days or 10 percent in 180 days. If there was a significant weight loss the physician and family should be notified. Resident 10's weight change was a 5 percent weight change, and the physician and family should have been notified. According to the weight flow sheet the physician was not notified. Notifications were normally completed by the staff nurse on the hall. During an interview on 11/22/17 at 11:01 a.m., the DON indicated the physician and family were not notified of the weight loss of 5 percent in 30 days. On 11/2/17 at 11:46 a.m., the DON provided a document titled, "Notification of significant changes in condition," and indicated it was the policy currently being used by the facility. The policy indicated, "PURPOSE: To keep the Resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affect the car and welfare of the Resident...POLICY: This facility shall immediately inform the Resident, consult with the Resident's physician, and, if known, notify the Resident's legal representative or an interested family member when there is:...(2) a significant change in the Resident's physical, mental,			

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	11/22/2017

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

(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
	or psychosocial status that constitutes a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications...." 3.1-5(a)(2)			
F 0166 SS=D Bldg. 00	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or			

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	11/22/2017

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

(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
	her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance			

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	11/22/2017

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

(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
	decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure a resident's personal belongings, hearing aid, were stored and maintained in a safe and secured environment for 1 of 30 residents questioned about missing personal property (Resident 42). Findings include: During a family interview, on 11/15/17 at 3:14 p.m., Resident 42's husband when queried about any missing personal	F 0166	I. Resident 42 has not been negatively affected by the loss of the hearing aid and replacement of the hearing aid has been completed. Resident 10's responsible party has expressed satisfaction with facility efforts to replace the lost hearing aid. II. In an effort to identify others who may have been affected in regard to loss of personal belongings, all residents were interviewed as to any missing items and appropriate action taken as warranted. III. As a means to ensure ongoing	12/21/2017

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	11/22/2017

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

(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
	items, indicated Resident 42's hearing aid was lost about a month ago, but he had not heard any update from the facility about the missing hearing aid. The staff claimed they looked for the item, but had not found the missing hearing aid. CNA (Certified Nursing Assistant) 112 had told the husband she had taken the hearing aids out of the resident's ears and placed the hearing aids at the nurses' station. The husband indicated he had spoken with the SSD (Social Services Director) about the missing hearing aid. She indicated she did not know what to do about the missing item. On 11/17/17 at 10:57 a.m., the SSD indicated she had not been told Resident 42's hearing aid was missing. Usually, if there was something missing, the staff would come and tell her. The ADM (Administrator), on 11/17/17 at 2:03 p.m., indicated Resident 42's husband had told her about the missing hearing aid yesterday afternoon. She was not aware nor had she been told by staff, the hearing aid had been missing. When an item was missing, the staff were supposed to look for the item and report the missing item to her, the Administrator. She made a reportable to the State, concerning the missing hearing aid. The staff should have reported the		compliance, staff received in-service training in regard to notification of Administrator for missing resident belongings. IV. As a means of quality assurance, residents will be interviewed twice monthly by the Social Services Director or her designee in regards to missing personal belongings or other grievances and appropriate staff notification. The results of the interviews will be provided to the Administrator. Should non-compliance be observed, corrective action shall be taken, including re-education and/or disciplinary action, as warranted. V. Evidence of the in-servicing is provided in Attachment B and Attachment D. Evidence of the monitoring is provided in Attachment E. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F166.	

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	11/22/2017

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

(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
	item was missing. Resident 42's record was reviewed on 11/20/17 at 9:22 a.m. Diagnosis included, but was not limited to, Alzheimer's dementia. A physician's orders, dated 2/21/17, indicated hearing aids, bilateral, in morning and out at bedtime; keep on medication cart. A nurses' note, dated 10/2/17 at 5:00 p.m., indicated, "...Still cannot find the R hearing aide. It was reported that aide, [aide's name], gave them both to [nurse's name] the Saturday night nurse and the next day she had in the L one but not the right one...." The resident's care plan lacked documentation Resident 42 wore hearing aids. The ADM provided and identified as current an undated, facility policy, titled "LOST OR STOLEN ITEMS," indicated, "...POLICY: It is the policy of this facility to conduct an investigation following the reporting of lost or stolen items. The Administrator or his/her designee shall be responsible for the investigation process...PROCEDURE: 1.) Should a resident or responsible party report an item as lost or stolen, a Report of Concern shall be completed and forwarded to the attention of the Administrator...5.) The Administrator or his/her designee shall orally or in written			

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	11/22/2017

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

(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
	form report to the resident or his/her legal representative the results of the investigation in the event the lost or stolen item is not recovered...." 3.1-7(a)(2)			
F 0247 SS=D Bldg. 00	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. Based on interview and record review the facility failed to give proper notification when residents had a room mate change, for 2 of 30 residents interviewed about prior notification. (Residents 56 and 61) Findings include: On 11/15/17 at 10:54 a.m., during an interview, Resident 61 indicated he had got a new room mate within the last 9 months. He was not sure how long ago the new room mate moved in. He was not notified he was getting a new room mate. They just started bringing stuff into the room. He thought he would get a room mate at some point because he had a	F 0247	I. Please note that residents #56 and #61 were not negatively affected as a result of the failure to notify of the incoming roommate. II. As all residents who receive new roommates could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with prior notification of a new roommate, the Administrator will conduct weekly checks with the Social Services Director to ensure timely completion of notices. 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.	12/21/2017

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	11/22/2017

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

(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
	previous room mate. On 11/15/17 at 11:24 a.m., during an interview, Resident 56 indicated she had got a new room mate, about a week ago . She was not given notice before the room mate arrived. She found out when they started moving her into the room. On 11/22/17 at 10:03 a.m., the Social Service Director (SSD) indicated, Resident 56's new room mate (Resident 72) came on the evening shift, on 11/14/17. Since SSD was not here, she was not notified. She indicated it was her responsibility to notify residents when they were getting a room mate change. If she had made a notification there would have been a SSD note in the resident's medical record, and her notes. There was no note for Resident 56. Resident 61's room mate (Resident 68), came in September. He also came on evening shift. No notification of room mate change was given. There was no SSD written because it was after she left for day. On 11/22/17 at 10:10 a.m., during an interview the Administrator indicated, sometimes they came so quickly, they were just here and there was not time for advance notification to be given. The hospital just sends them over.		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. Evidence of the monitoring is provided in Attachment F. Evidence of correctly issued notices are in Attachment G. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F247.	

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	11/22/2017

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

(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
	On 11/22/17 at 1:32 p.m., the Administrator indicated there was not a facility policy regarding room mate notification. They follow the "regulations". On 11/22/17 at 2:20 p.m., the Administrator provided a document, she identified as being from the current Resident Rights Regulations. The untitled document, dated 11/28/16, indicated, the resident has a right to share a room with his or her room mate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. 3.1-3(v)(2)			
F 0272 SS=E 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.			

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	11/22/2017

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

(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
	(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 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 ensure Minimum Data Set (MDS) assessments were accurate for 4 of 30 residents reviewed for MDS assessment accuracy (Residents C, 17, 39, and 28).	F 0272	I. 1-4. The MDS assessments of Residents C, 17, 39, and 28 have been corrected. II. 1-4. In an effort to identify others who may have been affected, a review will be conducted of all MDSs completed in the last two quarters to confirm	12/21/2017

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	11/22/2017

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

(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
	Findings include: 1. Resident C's record was reviewed on 11/20/17 at 9:46 a.m. An admission Minimum Data Set (MDS) assessment, dated 10/5/17, misidentified Resident C's first name. Resident C had a moderate cognitive impairment. Resident C's Medicare card indicated a different first name than what was indicated on the admission MDS assessment. An insurance card for a different resident, with the same first name as what was indicated in the admission MDS assessment, was observed in Resident C's chart. A continuity of care document, from the facility Resident C was admitted, indicated a different first name than what was on the admission MDS assessment. During an interview on 11/14/17 at 3:39 p.m., Resident C's family member indicated Resident C's name was not what was indicated on the admission MDS assessment. Resident C had never gone by the name on the admission MDS assessment. During an interview on 11/20/17 at 2:41		accuracy in resident name, diagnoses, and medication usage. 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 resident name, relevant health conditions, and medication usage. 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 aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the audit is provided in Attachment H. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F272.	

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	11/22/2017

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

(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
	p.m., the MDS coordinator indicated she was not sure why Resident C's name was incorrect on the comprehensive MDS assessment. The name on the MDS assessment should have been the same as what was on the Medicare card. During an interview on 11/20/17 at 2:51 p.m., the Administrator indicated she was not sure why Resident C's name was incorrect on the MDS assessment. The name on the MDS assessment should have been the same as what was on the Medicare card. 2. Resident 17's record was reviewed on 11/20/17 at 9:58 a.m. A diagnosis list in the admission record included, but was not limited to, a diagnosis of acute kidney injury. An annual Minimum Date Set (MDS) assessment, dated 7/30/17, indicated Resident 17 was severely cognitively impaired. Resident 17 did not receive antibiotics during the assessment look back period. A physician's order, dated 7/21/17, indicated Levaquin (an antibiotic) 500 milligrams (mg) by mouth for 1 dose, then 250 mg by mouth for the rest of the doses for 7 days.			

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	11/22/2017

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

(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
	A review of the Medication Administration Record (MAR) for July 2017 indicated Resident 17 received Levaquin July 21, 22, 23, 24, 25, 26, 27 and 28, 2017. During an interview on 11/20/17 at 2:40 p.m., the MDS coordinator indicated the Levaquin antibiotic should have been included on the MDS assessment from July 2017. It was missed. She was not sure why it was missed. 3. Resident 39's record was reviewed on 11/20/17 at 9:46 a.m. The diagnosis page of the the resident's record, dated 4/3/17, indicated the resident's diagnoses included, but were not limited to, psychosis. A document titled, "Psychopharmacological Medication Review," dated 4/4/17, indicated the consultant Pharmacist made a recommendation to update the resident's diagnoses to include psychosis. The physician's order's, dated 5/1/17 through 5/31/17, and signed by the physician on 5/2/17, indicated the diagnosis of psychosis. No documented diagnosis of psychosis was observed on the resident's annual			

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	11/22/2017

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

(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
	MDS assessment, dated 7/9/17. During an interview, on 11/20/17 at 1:56 p.m., the MDS Coordinator indicated the diagnosis of psychosis, added 4/3/17, had not been put on the annual MDS assessment, dated 7/9/17. She was unable to explain why the diagnosis was not placed on the annual MDS assessment.4. Resident 28's record was reviewed on 11/17/17 at 10:38 a.m. The resident's medication administration record included, but was not limited to, diagnoses of edema (swelling caused by excess fluid trapped in the body's tissue) and cellulitis (bacterial infection of the skin and tissues beneath the skin). A 30 day MDS (minimum data set) assessment, dated 11/4/17, indicated the resident did not receive medications (by pharmacological classification) that included: an antibiotic, and diuretic within the last 7 days of the assessment date. A review of the resident's physicians orders, dated October 26, 2017, included, but were not limited to, Keflex (antibiotic) 500 mg (milligram), give 1 tablet by mouth every 6 hours for 10 days for cellulitis, and Lasix (diuretic) 20 mg, give 1 tablet by mouth once daily for edema.			

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	11/22/2017

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

(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

A review of the medication administration record, included, but was not limited to, Keflex 500 mg and Lasix 10 mg were administered on 10/29, 10/30, 10/31/2017, and 11/1, 11/2, 11/3 and 11/4/2017.

A care plan, dated 10/26/2017, indicated the resident had a diagnosis of cellulitis of left foot and ankle and placed on an antibiotic for 10 days. Interventions included, but were not limited to, administer medications and treatments as ordered and monitor for adverse side effects.

During an interview on 11/20/17 at 9:58 a.m., the MDS (minimum data set) Coordinator indicated the assessment dated 11/4/17 was coded the resident did not receive an antibiotic and a diuretic, and was coded incorrectly because the resident had received both during the 7 day look back period.

A copy of Section A of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 11/20/17 at 2:55 p.m. The manual indicated, Section A: Identification Information... "The intent of this section is to obtain key

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	11/22/2017

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

(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
	information uniquely identify each resident, the home in which he or she resides, and the reasons for assessment... A0500, Legal Name of Resident: Item rationale allows identification of resident. Also used for matching each of the resident's records. Definition Legan Name: resident's name as it appears on the medicare card. If the resident is not enrolled in the medicare program, use the resident's name as it appears on a medicaid card or other government-issued document..." A copy of Section I of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 11/21/17 at 3:27 p.m. The manual indicated, Section I: Active Diagnoses... "The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status...." A copy of Section N of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI)			

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	11/22/2017

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

(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
	Version 3.0 Manual, was provided by the MDS Coordinator on 11/20/17 at 2:55 p.m. The manual indicated, Section N: Medications..."The intent of the items in this section is to record the number of days, during the last 7 days... that any type of... select medications were received by the resident... Antibiotic: Record the number of days an antibiotic medication was received by the resident at nay time during the 7-day look-back period... Diuretic: record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period...." 3.1-31(d)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the			

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	11/22/2017

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

(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
	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). (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.			

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	11/22/2017

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

(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
	(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 develop a comprehensive care plan for an antipsychotic medication (Resident 28) and skin integrity (Resident 62) for 2 of 30 residents reviewed for care plan development. Findings include: 1. Resident 28's record was reviewed on 11/17/17 at 10:38 a.m. The resident's profile included, but was not limited to, diagnosis of epilepsy (nerve cell activity in the brain disturbed, seizures). A 30 day MDS (minimum data set) assessment, dated 11/4/17, indicated the resident received an antipsychotic medication 7 days of the 7 day look back period. A review of the resident's physicians orders, dated November of 2017, included, but was not limited to, Seroquel (antipsychotic) 100 mg (milligram) tablet, take 1 tablet orally every evening. A review of the resident's medication administration record, dated November	F 0279	I. 1-2. The careplans of Residents #28 and #62 have been revised and updated to include medications used and skin integrity risk. II.1-2. In an effort to identify others who may have been affected, a review will be conducted of all careplans to confirm psychotropic drug use and skin integrity risk are addressed to ensure staff awareness of conditions and necessary care thereof. III. As a means to ensure ongoing compliance, the careplan coordinator has been educated in regard to developing a comprehensive careplan, including, but not limited to, medications and skin conditions. IV. As a means of quality assurance, at the time of careplan review for significant change in condition or quarterly review, the DON/designee shall review and confirm the comprehensive careplan 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 careplan to confirm said review.	12/21/2017

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	11/22/2017

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

(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 2017, indicated the resident received Seroquel 100 mg on 11/1/17 through 11/17/17. A review of care plans, no care plan for the use of an antipsychotic medication was found. During an interview on 11/17/17 at 1:52 p.m., RN 102 indicated the received Seroquel an antipsychotic medication for seizures, and no care plan for an antipsychotic medication was developed and one should have been. 2. Resident 62's record was reviewed on 11/21/17 at 9:32 a.m. The nursing admission assessment, dated 5/25/17, indicated the resident was admitted with a 2 cm (centimeter) by 4 cm, dark pink area on her coccyx. Braden Scale assessments (assessments to predict pressure ulcer risk), completed on 5/25/17, 6/1/17, 6/8/17, and 6/15/17, indicated the resident was high risk for development of pressure ulcers. The resident's admission MDS (Minimum Data Set) assessment, dated 6/8/17, indicated the resident was at risk for the development of pressure ulcers, but had no unhealed pressure ulcers at admission.		V. Evidence of the audit is provided in Attachment I. Due to the evidence provided, Williamsburg Health Care requests desk review/paper compliance on tag F279.	

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	11/22/2017

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

(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
	Review of the resident's current care plans, indicated no care plan for the resident being at risk for the development of pressure ulcers or impaired skin integrity. During an interview, on 11/16/17 at 2:51 p.m., LPN (Licensed Practical Nurse) 109 indicated Resident 62 had been admitted with a 2 cm by 4 cm, dark pink area on her coccyx. The area should have been documented as a stage I pressure ulcer to the coccyx and that no documentation was identified that indicated the area had been followed up on. During an interview, on 11/21/17 at 10:31 a.m., the Care Plan Coordinator indicated there was no care plan for skin integrity for the resident. She indicated there had been a catastrophic computer malfunction at the time the resident was admitted, and several care plans were lost. Those resident's care plans were re-entered into the system. Resident 62's skin integrity care plan had been overlooked when the care plans were re-entered into the system. On 11/20/17 at 3:10 p.m., the Administrator provided an undated document, titled, "Care Planning," and indicated it was the policy currently being			

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	11/22/2017

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

(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
	used by the facility. The policy indicated, "...The care plan...identifies...problems that the resident needs help with and includes goals for the to work towards...Problems include...skin issues...Developing a Care Plan: ...Nurses are responsible to ensure that every resident has a nursing plan of care that accurately identifies priority problems, targets outcomes and specifies nursing interventions...." 3.1-35(a)			
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,			

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	11/22/2017

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

(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
	and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure residents' skin conditions were assessed and documented. This had the potential to affect 3 of 3 residents reviewed for wounds (Residents 37, 58, and 62). Findings include: 1. On 11/20/17 at 10:33 a.m., LPN (Licensed Practical Nurse) 113 was observed to perform wound treatments for Resident 37 on both of his feet, right anterior lower leg, posterior thighs, coccyx area, scrotum, front abdominal folds, bilateral hands, and right shoulder. On 11/20/17 at 10:44 a.m., LPN 113 indicated the resident slept in his recliner,	F 0309	I. 1-3. Please note that residents #37, #58, and #62 were not harmed as a result of failure to document on their skin conditions. II. 1-3. In an effort to ensure the continued accuracy of assessing resident skin conditions, each resident currently having skin conditions including but not limited to cancerous lesions, cellulitis, and pressure areas were identified and necessary actions taken as warranted, including regular assessment of those areas. III. 1-3. As a means to ensure ongoing compliance with accurately assessing resident skin condition, a form has been created for nursing staff to complete weekly. Monitoring for compliance will be conducted by the DON or her designee weekly. Continued completion of the skin	12/21/2017

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	11/22/2017

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

(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
	which caused the abrasions on the back of his thighs, coccyx and scrotum. A waffle cushion was placed in the chair and they encouraged the resident to lay down on the bed to get some pressure off of the wounds, but the resident preferred to sleep and stay in his recliner. LPN 113 indicated, while she applied the treatments, the coccyx area was purple with approximately 4 cm (centimeters) of excoriation, his bilateral posterior thighs were purplish with 10 cm excoriation on each of the upper thighs with red to purple dry flaking skin. Resident 37's record was reviewed on 11/20/17 at 10:09 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and chronic kidney disease. A quarterly MDS (minimum data set) assessment, dated 10/10/17, indicated the resident had moisture associated skin damage. A review of the Resident 37's current physicians orders, dated November of 2017, indicated, 8/22/17 Mometasone Furoate 0.1% - Apply to purple/red intact skin on upper thighs and buttocks - one time weekly for maintenance; 3/17/16 Risamine Ointment - apply daily to buttocks after cleansing with soap and		condition assessments and subsequent action(s) taken will be reported to the Administrator. IV. 1-3. 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. Evidence of the form for resident skin condition review is provided in Attachment J. Evidence of the monitoring is provided in Attachment K. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F309.	

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	11/22/2017

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

(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
	water; 8/15/17 Mometasone Furoate 0.1% (Elocon 0.1% cream) - After soap & water cleanse, apply to right anterior lower leg redness 1 x weekly for maintenance (Monday); 8/24/16 Mupirocin 2% ointment (Bactroban 2% ointment) apply as needed daily to area on right hand after soap & water cleanse then cover w/ telfa island dressing for flare ups; 2/15/16 Volataren 1% gel apply to arthritic shoulder and hands (up to 2 gm) 2 times daily routinely and 2 times daily if needed for pain; 3/17/16 Nystatin powder 100,000 unit apply 2 times daily to testicles and abdominal folds; and 9/14/17 Continue treatments as ordered by wound center 9/12/17. Also change mepilex to upper thighs and buttocks prn (as needed) and use Calmoseptine cream to buttocks daily after washing with soap and water. Change to QD (every day) instead of prn (as needed). A care plan, revised 1/1017, indicated, " ...I have a history of red or open areas. 1/5/17 Seen at local wound clinic, diagnosed with stage III (full thickness tissue loss) pressure area to right buttock. 1/10/17 wound is only pinpoint in size. I may be at risk to develop additional skin breakdown ...Interventions ...Assess my skin at least two times per week on my shower days. Document any red or skin areas, include location, size, stage in			

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	11/22/2017

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

(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
	documentation ...Should direct caregiver observe red or open area, it should be reported to charge nurse at once ...Report development of red or open areas to physician ...." A review of the resident's shower skin assessments, dated 11/2, 11/6, 11/9, and 11/11/17, indicated the resident had no skin issues. On 11/20/17 11:02 a.m., LPN 113 indicated, wound treatments were only documented in the TAR binder, when performed on a resident. On 11/21/17 at 12:38 p.m., the DON (Director of Nursing) indicated, the facility documented on pressure ulcers, no other wounds, only pressure ulcers in the nurses' notes. She indicated they should be documenting on all the residents' wounds or skin abrasions. On 11/17/17 at 2:11 p.m., ADM indicated, they knew there was an issue for skin areas and wound documentation. They were working on fixing the wound documentation issues. 2. Resident 58's record was reviewed on 11/20/17 at 11:12 a.m. The resident's profile included, but was not limited to, diagnosis of muscle weakness.			

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	11/22/2017

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

(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
	An observation, on 11/17/17 at 10:36 a.m., the resident was in room and white foam dressing to the left ear was intact. An observation, on 11/20/17 at 2:47 p.m., during an observation of a dressing change the resident's ear was red in color, swollen, and had an open area. A review of progress notes, dated 10/11/17 at 11:00 p.m., indicated dressing changed to left ear. Moderate amount of blood present due to scab area picked by resident. An annual MDS (minimum data set) assessment, dated 11/11/17, indicated the resident had an open lesion area. A review of the resident's current physicians orders, dated November of 2017 with a start date of 9/8/17, indicated, apply kendall foam border dressing, apply to left face/ear after cleansing daily as needed for bleeding. A care plan, revised 9/13/2017, indicated the resident was at risk to experience skin breakdown due to needing staff assistance with bed mobility. Interventions included, but were not limited to, assess my skin at least two times per week on shower days. Document any red or open skin areas			

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	11/22/2017

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

(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
	observed, include location, size, and stage in documentation. A review of the resident's shower skin assessment, dated 9/8, 9/12, 9/16, 9/23, 9/26, 9/30/2017, and 10/3, 10/7, 10/10, 10/14, 10/21, 10/24, 10/31/17, and 11/7, 11/11, and 11/14/17, indicated the resident had no skin issues to the face or left ear. During an interview on 11/20/17 at 11:39 a.m., the DON (Director of Nursing) indicated the resident had an open area to the left ear. The skin assessments were done weekly on the shower days and indicated there was no documentation on the shower sheets of the open lesion area to the left ear and per policy the nurse's should document the open lesion area to the left ear on the shower sheets and had failed to do so. During an interview on 11/20/17 at 1:41 p.m., LPN 104 indicated the resident had an open lesion area to the left ear. 3. Resident 62's record was reviewed on 11/21/17 at 9:32 a.m. The nursing admission assessment, dated 5/25/17, indicated the resident was admitted with a 2 cm (centimeter) by 4 cm, dark pink area on her coccyx.			

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	11/22/2017

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

(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

Braden Scale assessments (assessments to predict pressure ulcer risk), completed on 5/25/17, 6/1/17, 6/8/17, and 6/15/17, indicated the resident was high risk for development of pressure ulcers.

The resident's admission MDS (Minimum Data Set) assessment, dated 6/8/17, indicated the resident was at risk for the development of pressure ulcers, but had no unhealed pressure ulcers at admission.

Review of the resident's current care plans, indicated no care plan for the resident being at risk for the development of pressure ulcers or impaired skin integrity.

During an interview, on 11/16/17 11:10 a.m., the DON (Director of Nurses) indicated that skin areas were documented in the nurses notes and that she reads over them every morning. She also indicated that skin was checked by nurses on shower days and that if there was a skin issue it was documented on the shower skin assessment form.

During an interview, on 11/16/17 at 2:51 p.m., LPN (Licensed Practical Nurse) 109 indicated Resident 62 had been admitted with a 2 cm by 4 cm, dark pink

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	11/22/2017

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

(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
	area on her coccyx. The area should have been documented as a stage I pressure ulcer to the coccyx and that no documentation was identified that indicated the area had been followed up on. On 11/17/17 at 2:00 p.m., the Administrator provided an undated document, titled, "Treatment and Documentation," and indicated it was the policy currently being used by the facility. The policy indicated, "Skin lesions and decubitus (also called pressure or open wound) ulcers must be documented on a separate form from the nursing notes...It is the responsibility assigned nurse...to see that the physician is informed immediately upon Stage 1 and updated regularly...when a new decub or skin lesion occurs, a new form should be initiated immediately...When physicians change the treatment order, the nurse noting the order is responsible for changing the treatment charting record and notifying appropriate staff of the changes in orders...." 3.1-37(a)			
F 0329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM			

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	11/22/2017

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

(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
Bldg. 00	UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on record review and interview,	F 0329	I. Please let it be noted that	12/21/2017

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	11/22/2017

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

(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
	the facility failed to ensure a gradual dose reduction (GDR) was completed for 1 of 5 residents reviewed for unnecessary medications (Resident 17). Findings include: Resident 17's record was reviewed on 11/20/17 at 9:58 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/28/17, indicated Resident 17 had a moderate cognitive impairment. Resident 17 received antipsychotic, antianxiety, and antidepressant medication. No behaviors were documented. A diagnosis list in the admission record included, but was not limited to, diagnoses of altered mental status, encephalopathy, depression, and anxiety. A physician's order, dated 11/14/17, indicated increase Zyprexa (an antipsychotic medication) to 5 milligrams (mg) by mouth every night at bedtime. A previous physician's order, dated 10/10/17, indicated olanzapine (generic Zyprexa) 2.5 mg by mouth at bedtime for dementia with psychotic behaviors and stop Seroquel. A physician's order, dated 7/11/17, indicated sertraline (an antidepressant		resident #17 was not negatively affected as a result of the declined gradual dose reduction (GDR). II. In an effort to identify others who may have been affected in regard to appropriate clinical rationale for declined GDRs, all residents currently receiving psychotropic drugs shall be audited for declined GDRs and presence of a documented clinical contraindication. Should concern with past declined GDRs and appropriately documented clinical rationale be noted, a GDR will be re-addressed with the physician and documented. III. As a means to ensure ongoing compliance with appropriate implementation of GDRs, at the time of a requested GDR, the DON/designee shall review to ensure any declination of a GDR be accompanied by appropriate clinical rationale. Should non-compliance be observed, continued communication with the physician or medical practitioner will occur. The DON/designee shall sign to indicate review of the physician GDR response. 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. Evidence of the monitoring is provided in Attachment L. Due to the evidence provided,	

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	11/22/2017

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

(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
	medication) 150 mg by mouth once a day for depression. A physician's order, dated 9/22/14, indicated alprazolam (an antianxiety medication) 0.25 mg by mouth daily at 2:00 p.m. for anxiety. A physician's order, dated 9/12/17, indicated divalproex (a mood stabilizer) delayed release 125 mg by mouth 3 times a day for mood stabilizer. A subsequent physician's order, dated 11/14/17, indicated discontinue (DC) divalproex. A physician's order, dated 10/9/14, indicated mirtazapine (an antidepressant medication) 7.5 mg by mouth at 9:00 p.m. for depression and appetite. A psychopharmacological medication review, dated 1/30/17, indicated at that time Resident 17 received Seroquel (an antipsychotic medication), Xanax (an antianxiety medication), Zoloft (an antidepressant medication), Remeron (an antidepressant medication), and Benzotropine (an anti tremor medication). The pharmacist recommended to evaluate if gradual dose reduction (GDR) was appropriate. The Nurse Practitioner (NP) declined to do a GDR. There was no documentation of a clinical contraindication that was likely		Williamsburg Health Care requests paper compliance on tag F329.	

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	11/22/2017

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

(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
	to impair the function of Resident 17 to support the declination of the GDR. A psychopharmacological medication review, dated 5/1/17, indicated a GDR was not due. A psychopharmacological medication review, dated 8/7/17, indicated a GDR was not due. The Zoloft was increased in June and July 2017. No behaviors were documented on behavior monitoring forms for September, October, and November 2017. A psychiatric progress note, dated 2/14/17, was reviewed. There was no documentation of a clinical contraindication that was likely to impair the function of Resident 17 to support the declination of the GDR. During an interview on 11/20/17 at 2:01 p.m., the Director of Nursing (DON) indicated she was not sure if there should have been a patient specific rationale documented for why the GDR was declined. The psychiatric NP handled the GDR's. The NP would not normally document a patient specific clinical contraindication.			

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	11/22/2017

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

(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
	During an interview on 11/20/17 at 3:09 p.m., the Administrator indicated there should have been documentation of a clinical rationale for why a GDR was clinically contraindicated. There was no documentation on the GDR form. On 11/20/17 at 2:52 p.m., the DON provided a document titled, "Use of Antipsychotic Medications/Gradual Dose Reductions," and indicated it was the policy currently being used at the facility. The policy indicated, "POLICY: ...Residents who use antipsychotic drugs will receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. PROCEDURE: ...4. Gradual dose reductions for Residents with ordered antipsychotic medication as follows: ...After the first year, a GDR must be attempted annually, unless clinically contraindicated. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, a GDR may be considered clinically contraindicated if: Resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; *and* The physician has documented the clinical rationale for why an additional attempted dose reduction at that time would be likely to impair the			

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	11/22/2017

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

(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
	Resident's function or increase distressed behavior...." 3.1-48(a)(3)			
F 0333 SS=D Bldg. 00	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure a licensed nurse or respiratory therapist (RT) was with a resident during a nebulizer treatment, and that a resident's was assessed before and after a nebulizer treatment for 1 of 1 nebulizer treatment observations (Resident 40). Findings include: During a tracheostomy care and nebulizer treatment observation on 11/21/17 at 11:58 a.m., RT 105 placed Resident 40 on a nebulizer treatment via tracheostomy (a surgically placed hole in the neck). RT 105 did not assess Resident 40's vital signs or lung sounds prior to the administration of the nebulizer treatment. RT 105 then left Resident 40's room and indicated she did not normally stay with	F 0333	I. Please note that resident #40 was not harmed as a result of failure to document pre and post nebulizer treatment assessments and of the failure of RT to remain with resident. II. As all residents who receive nebulizer treatments could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with accurately administering nebulizer treatments, licensed nursing staff have received in-servicing on nebulizer treatments and pre and post treatment assessments. IV. As a means of quality assurance, following aforementioned training, the DON/designee shall conduct random observations of staff performing nebulizer treatments and assessments four times weekly on varied shifts to confirm compliance with facility policy.	12/21/2017

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	11/22/2017

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

(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
	Resident 40 during the nebulizer treatment. On 11/21/17 at 12:18 p.m., RT 105 was observed to have removed Resident 40 from the nebulizer treatment. RT 105 did not assess Resident 40's vital signs or lung sounds after the administration of the nebulizer treatment. During an interview on 11/21/17 at 2:11 p.m., the Director of Nursing (DON) indicated if a resident was going to be left alone on a nebulizer there should have been a self administration of medications assessment completed. There should have been a physician's order for self administration of medication. A lung assessment, pulse, and whatever other assessment requirements were indicated on the Nebulizer Treatment Flow Sheet should have been completed. Respiratory therapy was responsible for this documentation if they were administering the nebulizer treatment. During an interview on 11/21/17 at 2:21 p.m., Licensed Practical Nurse (LPN) 109 indicated a resident who received a nebulizer by tracheostomy should not have been left alone during a nebulizer treatment. During an interview on 11/21/17 at 2:39		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. Evidence of the in-servicing on nebulizer treatments is provided in Attachment B. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F333.	

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	11/22/2017

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

(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
	p.m., the DON indicated Resident 40 had never self administered medications. During an interview on 11/21/17 at 3:54 p.m. the DON indicated Resident 40 should have had a nebulizer flow sheet, but he did not have one in place. Patients that were on ventilators did not have the flow sheets to document pre and post nebulizer assessments and that should be changed. During an interview on 11/22/17 at 3:00 p.m., Resident 40 indicated staff would not always stay with him during his nebulizer treatments. Resident 40's record was reviewed on 11/21/17 at 9:55 a.m. A diagnosis list in the admission record included, but was not limited to, diagnoses of dependence on ventilator status, tracheostomy status, and chronic obstructive pulmonary disease unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 11/11/17, indicated Resident 40 had a moderate cognitive impairment. Resident 40 was totally dependent for activities of daily living (ADL's). A physician's order, dated 12/27/11, indicated ventilator on at bedtime and off			

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	11/22/2017

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

(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
	every morning. A physician's order, dated 2/14/14, indicated ipratropium-albuterol (a nebulizer treatment) 0.5-3(2.5) milligrams (mg), 1 unit dose via nebulizer every 4 hours while awake. Reviewed nurse's notes for November 2017 with no documentation of lung assessments or vital signs before or after nebulizer treatments observed. On 11/21/17 at 12:30 p.m., the Administrator provided a document titled, "Nebulizer, Hand Held (Small Volume)," and indicated it was the policy currently being used by the facility. The policy indicated, "PURPOSE: Hand held nebulizers are used to administer medication to the respiratory tract through the use of air. POLICY: Hand held nebulizer treatments will be administered only by licensed staff or a respiratory therapist as ordered by a physician. PROCEDURE: ...5. Assess Resident and establish baseline respiratory rate, heart rate and breath sounds...9. Turn on the stationary delivery apparatus. Administer medication until depleted...NOTE: If the Resident is confused/disoriented, the Resident will be monitored by nursing personnel to ensure appropriate			

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	11/22/2017

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

(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
	placement of the delivery device until the treatment is completed. 10. Assess the Resident's response and effectiveness of therapy by auscultation of lung sounds, and obtaining respiratory rate and pulse rate post therapy...." 3.1-25(b)(9)			
F 0353 SS=E Bldg. 00	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e)			

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	11/22/2017

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

(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 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. Based on interview and record review, the facility failed to ensure sufficient direct care nursing staff were on duty to provide nursing care for 12 of 30 residents reviewed for sufficient nursing staff (Residents B, C, D, E, F, G, H, I, J, K, L, and N). Findings include: Anonymous interviews with residents and resident's family members included the following: Resident B indicated, he has had to wait up to two hours for his call light to be	F 0353	I and II. As all residents could be affected, all residents (which will include, Residents #B, C, D, E. F, G,H, I, J, K, L and N) will be interviewed regarding concerns with staffing and corrective action plans initiated regarding call light response time, assistance for personal care, assistance to bed and assistance with toileting, as per individual concerns. The DON and/or Designee will observe all residents during routine daily rounds on scheduled days of work to ensure resident personal care is provided timely for residents, call lights are answered timely, and residents are also toileted timely. Any noncompliance noted will be immediately corrected and/or	12/21/2017

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	11/22/2017

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

(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
	answered or sometimes they would answer the light and say they would come back. It was not worse at any certain time of day, and could happen anytime. Resident C indicated, there was not enough staff, he had waited up to an hour for the call light to be answered and it was worse at supper time. Resident D indicated, she had to wait up to an hour for staff to come and help her go to bed. They answered the call light and said they would come back, but it took up to an hour. Resident E indicated, she had to wait a long time to get help, when she used her call light. The facility was short of help. Resident F indicated, there was not enough staff, they got busy and it took them a while to come and check on him, when he pusheed his call light. Resident G indicated, they do not have enough staff, usually 2 girls on the floor/unit. They did not answer call lights promptly. Resident G had waited an hour for the staff to come and see what was needed. Resident G had seen 20 call lights on at the same time with only 2 aids helping everyone. Resident H indicated, there were not		employee disciplined as appropriate. Staff scheduling will be reviewed each shift according to resident needs by the DON and/or Designee. Adjustments will be made to ensure resident needs are met. III. The facility has placed ads with recruiting entities, contacted local colleges and reviewed and enhanced employee benefits in an effort to recruit staff to reduce the amount of overtime and possible staff burnout. Administration and nursing administration have met to review current acuity and staffing patterns in an effort to ensure staff are best utilized in response to residents' plans of care. Nursing management has been re-educated on assessing the need for a sufficient amount of staff to care for the residents. Nursing staff shall be addressed in regard to ensuring the correct number of caregivers are present as per plan of care, timely response to call lights toileting and personal care and of the need to notify administration should unexpected staffing vacancies be such to prohibit the meeting of resident needs per plan of care. IV. As a means of quality assurance, and in an effort to ensure a sufficient amount of staff is present, the DON or designee will complete the	

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	11/22/2017

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

(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
	enough CNAs (Certified Nursing Assistant) to help all the residents. Sometimes, Resident H had to wait a long time to get a call light answered. Resident I indicated, there was not enough staff at times, especially during evening shift, she had to wait a long time for help. Resident J indicated, there was not enough aids, especially in the evening, at supper time, Resident J ate in the dining room and there were times where there was no staff in there. The evenings they did not have enough staff to help everyone. Sometimes, Resident J had to wait an hour or two to get assistance. The staff were busy and could not get to everyone quickly. During a family interview, Resident K's family member indicated, there were times when they did not have as much staff as there should be at the facility. There was only one or two CNAs for the unit. Resident K was a stand up lift for transfers, but only had one CNA to transfer her using the lift at times. The nurse was supposed to assist with transfers, when there was only one aid, but she was busy with other residents. On 11/16/17 at 9:58 a.m., Resident L		staffing schedule reviews daily for 4 weeks, then weekly for four weeks, monthly times two and then quarterly until compliance with ensuring sufficient nursing staff is maintained. Daily rounds on scheduled days of work at random times and on random shifts will be conducted in an effort to assess sufficiency of staff as evidenced by ability to care for the residents according to their careplans and provide timely response to resident needs. Results of the rounds, staffing schedule reviews and any additional corrective action taken shall be reviewed with the Administrator on a weekly basis and also reported to the Quality Assurance Committee during quarterly meetings and the plan revised (e.g., extended if concerns persist), if warranted. V. Evidence of the schedule reviews and monitoring is provided in Attachment M. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F353.	

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	11/22/2017

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

(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
	indicated, the facility did not have enough staff assisting residents, she had seen call lights go off not answered for 30-45 minutes. During a family interview, Resident N's family member indicated, the facility did not have enough staff to meet the needs of all the residents in the facility, she could not find anyone when visiting the facility with seven call lights going off at the same time and only two staff assisting a resident in one room. Anonymous interviews with direct care staff, nurses and CNAs, included the following: Employee 2 indicated, it was hard to assist all the residents with eating and answer call lights to assist other residents with their needs. The CNAs assisted the residents with ventilators with eating. If they are assisting a resident the nurse had to answer call lights; three CNAs were assigned during the day, but only two CNAs at supper time. Employee 3 indicated, the facility had been short of staff for months and all the staff had been required to work 12 hour shifts to compensate. All the staff had been pulling a lot of extra hours and were tired.			

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	11/22/2017

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

(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
	Employee 4 indicated, the facility went to 12 hour shifts due to staff shortages. Staff were not always able to check and change residents for incontinence due to the number of heavy care residents and not enough staff on duty. Employee 5 indicated, some night shifts only had three CNAs for the entire building and they were supposed to have a minimum of four or five aids to assist the residents at supper time with eating in the dining room and the residents whom need help eating in their rooms. Employee 6 indicated, of course they had sufficient staffing problems. The facility was using 3 staffing agencies to help compensate for the short staffing issues of the facility. The agency staff were calling off work too, which caused a staffing shortage too, especially on Desk One, since they had 7 ventilator dependent residents. The facility had contacted former staff and were rehiring old employees whom had left and/or quit in the past. Employee 7 indicated, there were times when there was not enough staff on either shift, and they could not always check and change residents or adequately supervise residents in the dining room.			

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	11/22/2017

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

(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
	There were a lot of residents requiring lift transfers and 2 person transfers. Review of the current residents in the facility, indicated a census of 45 residents with 24 residents required two staff to transfer them. On 11/22/17 at 12:01 p.m., a copy of the Resident Council Minutes, with follow-up, for the past 6 months, was provided by the Activity Director. Review of the resident council minutes, indicated short staffing and waiting long times for call lights to be answered was a regular problem, and was brought up often at the Resident Council meetings. The facility stated they were working on it but it was ongoing problem. There was not a lot they could do when someone called in, at the last minute. They tried to get substitutes but they could not always get replacements. They had to do what they could. They said they were trying to work towards getting more, enough, staff to fill the open positions. An interview with the ADM (Administrator) on 11/22/17 at 2:15 p.m., indicated they had had a number of resignations and terminations for the last several months. The facility was utilizing three staffing agencies, since September 2017, due to the low staff numbers, but			

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	11/22/2017

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

(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
	the facility still had low numbers of staff at times, due to call-ins and staff just not showing up for work. This Federal tag relates to Complaint IN00245125. 3.1-17(a)			
F 0441 SS=D 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;			

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	11/22/2017

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

(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
	(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.	F 0441	I. The applicable caregivers were	12/21/2017

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	11/22/2017

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

(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
	Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures and hand hygiene were maintained for 2 of 2 residents observed during a wound care observation (Resident 37 and Resident 49); and for 1 of 1 resident observed for tracheostomy (a surgically placed hole in the neck) care and administering a nebulizer treatment (Resident 40). Findings include: 1. On 11/20/17 at 10:33 a.m., LPN (licensed practical nurse) 113 was observed to perform wound treatments for Resident 37 on both of his feet, right anterior lower leg, posterior thighs, coccyx area, scrotum, front abdominal folds, bilateral hands, and right shoulder. LPN 113 entered Resident 37's room, while she carried the TAR (treatment administration record) binder and a plastic bowl container, which held 5 plastic bagged ointments, creams, and lotions. The bowl container was placed onto the resident's bedside table without a protective barrier and the TAR binder was placed onto the resident's bed. LPN 113 assisted Resident 37 to stand barefooted on a towel and hold onto his walker, while she applied the treatments. LPN 113 donned gloves without		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. Evidence of the in-servicing is provided in Attachment B. Evidence of the random observations is provided in Attachment N. Due to the evidence provided, Williamsburg Health Care requests desk review on tag F441.	

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	11/22/2017

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

(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
	performing hand sanitation, and applied an antifungal cream to Resident 37's feet. With the same soiled gloved hands, LPN 113 placed the lotion back into a plastic baggy and put the plastic bag back into the bowl container, retrieved another bagged cream from the bowl container, while she wore the same soiled gloves. She then applied the cream (mometasone furoate 0.1% cream) to the right anterior lower leg and coccyx area. She removed her gloves, washed her hands for < (less than) 6 seconds and turned off the faucet with her bare hand. LPN 113 donned new gloves, reached into the bowl container, grabbed another bagged cream (ammonium lactate 12% lotion) and applied this cream to Resident 37's feet. She removed her gloves, washed her hands for < 5 seconds and turned off the faucet with her bare hand. LPN 113 then donned new gloves and put socks onto Resident 37's feet. With the same gloves, she reached into the bowl, grabbed another bagged cream of volataren gel and a plastic applicator, measurement dosing card, measured the gel onto the applicator, applied the gel utilizing the applicator to spread the gel onto the resident's right shoulder, then applied more gel onto the plastic applicator and treated the resident's right hand, then applied more gel onto the plastic applicator and applied the gel on the left			

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	11/22/2017

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

(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
	hand. LPN 113 carried the plastic applicator, measurement dosing card, to the resident's bathroom sink, rinsed the applicator with water, placed the wet measurement dosing card and the volataren gel back into a baggy, then placed the baggy back into the plastic bowl container with the other bagged ointments. While Resident 37 remained standing and bracing himself with the walker, LPN 113, while she wore the same soiled gloves and without hand sanitation, applied a mepilex border patches to both upper thighs, proceeded to apply nystatin powder to the scrotum, then she reached from behind the resident and in between his legs and indicated she applied nystatin powder to the resident's front abdominal folds. LPN 113 took off the soiled gloves, documented on the TAR the treatments performed, grabbed the bowl container and TAR binder and exited the room without performing hand sanitation. On 11/20/17 at 10:55 a.m., LPN 113 proceeded across the hallway to Resident 49's room, placed the TAR binder and bowl container onto a bed, applied a gait belt onto Resident 49 and assisted him into the restroom without any hand sanitation nor gloves. LPN 113 retrieved the TAR binder and the bowl container from the bed, exited the room. LPN 113			

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	11/22/2017

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

(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
	went to room 43, placed the TAR binder and the bowl container onto a resident's bed and assisted the resident with opening a drink container. LPN 113 retrieved the TAR binder and plastic bowl from the bed, exited the room, proceeded to the nurses' desk and placed the TAR binder and bowl container onto the nurses' desk and sanitized her hands. On 11/20/17 11:02 a.m., LPN 113 indicated, she should have washed her hands between gloves changes, when she finished with the Resident 37's wound treatments, and before assisting another resident. She should have washed her hands for 2 to 3 minutes each time or used hand sanitizer. On 11/17/17 at 11:25 a.m., the ADM (Administrator) indicated staff should wash or sanitize their hands when they enter or exit a resident's room and between glove changes, and during wound treatments. Staff should not take residents' medications/ointments cream containers into others residents rooms. LPN 113 should have washed her hands after assisting a resident to restroom. 2. On 11/21/17 at 11:58 a.m., Respiratory Therapist (RT) 105 was observed providing tracheostomy (a surgically placed hole in the neck) care			

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	11/22/2017

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

(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
	and administering a nebulizer treatment to Resident 40. RT 105 entered Resident 40's room and applied gloves. She did not wash her hands prior to applying the gloves. RT 105 suctioned Resident 40's tracheostomy, removed the dressing around the tracheostomy, cleansed the area under the dressing, dried area that was cleansed, applied a new dressing, and applied the nebulizer treatment. RT 105 did not change gloves or wash her hands after removing the old dressing. RT 105 left Resident 40's room, and did not wash her hands prior to leaving the room. On 11/21/17 at 12:18 p.m., RT 105 was observed in Resident 40's room. The nebulizer treatment was removed, and Resident 40's tracheostomy was suctioned. RT 105 removed gloves, and left room. RT 105 did not wash her hands prior to leaving Resident 40's room. During an interview on 11/21/17 at 2:11 p.m., the Director of Nursing (DON) indicated staff should have washed their hands upon entering the resident's room, when the clean dressing was applied, and once care was completed prior to leaving the resident's room. Resident 40's record was reviewed on			

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	11/22/2017

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

(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
	11/21/17 at 9:55 a.m. A diagnosis list in the admission record included, but was not limited to, diagnoses of dependence on ventilator status, tracheostomy status, and chronic obstructive pulmonary disease unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 11/11/17, indicated Resident 40 had a moderate cognitive impairment. Resident 40 was totally dependent for activities of daily living (ADL's). A physician's order, dated 10/28/11, indicated tracheostomy care every shift. A physician's order, dated 12/27/11, indicated ventilator on at bedtime and off every morning. A physician's order, dated 2/14/14, indicated ipratropium-albuterol (a nebulizer treatment) 0.5-3(2.5) milligrams (mg), 1 unit dose via nebulizer every 4 hours while awake. On 11/20/17 at 11:30 a.m., the ADM provided and identified as current, an undated facility policy titled, "Handwashing," which indicated, "...Policy: It is the policy of this facility that all staff will wash their hands effectively and appropriately to control			

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	11/22/2017

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

(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
	the spread of infection...Procedures and Practices...1. Hands should be washed:...A. Upon reporting for duty...B. Before and after each procedure...C. After touching excretions (feces, urine, or material soiled with them) or secretions (from wounds, skin infections, etc.) before touching any resident again...D. After caring for an infected or contaminated resident...E. Before touching wounds...F. Before touching a resident who is susceptible to infection...H. Before and after preparation of medication...J. Before and after the use of sterile gloves...K. After handling the resident's belongings...L. Whenever in doubt...2. Hands must be thoroughly washed immediately after contact with blood, body fluids, or tissues...3. When washing hands follow this procedure...G. Wash your fingers by spreading them wide and interlocking the fingers of both hands and rubbing together. Continue this process for at least 40 seconds...J. After drying hands, use a paper towel to turn off the water faucet...." On 11/20/17 at 11:30 a.m., the ADM provided and identified as current, an undated facility policy titled, "Policy for Treatments," which indicated, "...Two gloves will be used for all treatments requiring both hands to come in contact			

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	11/22/2017

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

(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
	with the resident. Hand washing will be done before gloving and after removing gloves...Procedure for gloving to do a treatment...1. Wash hands...2. Gather supplies...3. Explain procedure to resident...4. Put on gloves...9. Do treatment...11. Remove gloves...12. Wash hands...." On 11/21/17 at 12:30 p.m., the Administrator provided a document titled, "Tracheostomy Care," and indicated it was the policy currently being used by the facility. The policy indicated, "PROCEDURE: 1. Wash hands and apply non-sterile gloves...12. Discard gloves and wash hands...After Care of Equipment:...3. Wash your hands...." On 11/21/17 at 12:30 p.m., the Administrator provided a document titled, "Nebulizer, Hand Held (Small Volume)," and indicated it was the policy currently being used by the facility. The policy indicated, "PROCEDURE:...3. Wash hands or utilize alcohol gel prior to setting up equipment...13. Wash hands...." 3.1-18(l)			