STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW MANOR	3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00283004. Complaint IN00238004 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F690. Survey dates: January 2, 3, 4, 7, 8, & 9, 2019 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census Bed Type: SNF/NF: 113 Total: 113 Census Payor Type: Medicare: 15 Medicaid: 84 Other: 14 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 18, 2019.	F 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after February 8, 2019.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure residents were treated in a dignified manner for 6 of 11 residents reviewed. Residents wheelchairs were labeled	F 0550	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*	02/08/2019

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	with names, residents waited for assistance, residents were served meals in the dining room on bedside tables, and resident's doors were not closed during care. (Resident 35, Resident 96, Resident 109, Resident 28, Resident 1, Resident 56) Findings include: 1. During an observation in the dining room on 1/2/19 at 11:45 A.M., Resident 35 was observed sitting in a wheelchair at a dining room table. Located on the back of her wheelchair, written in large type on a piece of beige masking tape, was the resident's name. During an observation on 1/7/19 at 8:41 A.M., Resident 35 was observed sitting in her wheelchair in the lounge area. Located on the back of her wheelchair, written in large type on a piece of beige masking tape, was the resident's name. The clinical record for Resident 35 was reviewed on 1/3/19 at 11:00 A.M. The record indicated Resident 35's diagnoses included, but were not limited to, anxiety, depression, dementia, and cerebrovascular accident. The Quarterly MDS (Minimum Data Set) assessment, dated 11/7/18, indicated Resident 35 was cognitively impaired. The assessment further indicated Resident 35 required the assistance of one staff for bed mobility, transfers, and toileting. During an interview on 1/7/19 at 8:45 A.M., the Unit Manager for E and F hall indicated that the resident had no consent forms signed giving permission to place her name within public view.		It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Unless consented to in writing, resident names have been removed from wheelchairs and other durable medical equipment (DME) in the facility. It is the policy of this provider to respond to requests for assistance in a timely manner. In order to track our performance in responding to requests for assistance, we have implemented a call light audit process designed to improve response times. It is the policy of this provider to treat each resident with dignity and respect, including in the dining room. Residents eating away from other residents, either on tray tables or bedside tables, but not in their rooms, will be care planned for such either due to personal preference or other clinically-necessary reasons. Additionally, dignity and respect for resident privacy will be provided when providing care in resident rooms. Doors will be closed and/or curtains drawn closed when care is being provided to all residents. *How will other residents having the potential to be affected by the same alleged deficient practice be*	

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	During an interview on 1/7/19 at 11:06 A.M., the Administrator indicated it was the facility's policy not to place resident names on equipment that was within public view without their consent. 2. During an interview on 1/3/19 at 1:45 P.M., Resident 96 indicated he used his call light a couple of weeks earlier because he needed the bed pan. He indicated he had to wait 59 minutes before a CNA responded to his call light. While waiting, Resident 96 had a bowel movement in his pants. When the CNA finally answered the call light, she told him that was the way it was whenever you had to take care of 40 people. Resident 96 indicated that many times it took longer than 30 minutes to get a CNA to respond to a call light. The clinical record for Resident 96 was reviewed on 1/4/19 at 10:32 A.M. The record indicated Resident 96's diagnoses included, but were not limited to, anxiety, depression, and diabetes. The Quarterly MDS (Minimum Data Set) assessment, dated 12/18/18, indicated Resident 96 experienced no cognitive impairment. The assessment further indicated Resident 96 required the assistance of two staff for bed mobility, transfers, and toileting. Resident 96 was totally dependent on assistance for showers, was occasionally incontinent of bladder and always incontinent of bowels. The CNA Assignment Sheet dated 12/27/18 indicated that Resident 96 needed a mechanical lift for transfers and was incontinent. The Resident Council Minutes dated 10/24/18 were provided by the Activities Director 1/2/19 at 10:45 A.M. The Resident Council Minutes read		*identified and what corrective action(s) will be taken?* Unless consented to in writing, resident names have been removed from wheelchairs and other durable medical equipment in the facility. It is the policy of this provider to respond to requests for assistance in a timely manner. In order to track our performance in responding to requests for assistance, we have implemented a call light audit process designed to improve response times. It is the policy of this provider to treat each resident with dignity and respect, including in the dining room. Residents eating away from other residents, either on tray tables or bedside tables, but not in their rooms, will be care planned for such either due to personal preference or other clinically-necessary reasons. Additionally, dignity and respect for resident privacy will be provided when providing care in resident rooms. Doors will be closed and/or curtains drawn closed when care is being provided to all residents. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?*	

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	as follows: "...Nursing- [Residents Name] Resident 96 had a problem with a nurse falling asleep. [Resident's name] was concerned with a staff member who answered his call light and said she would notify CNA that he needed changed. Then he waited for an hour before getting assistance..." 3. On 1/2/19 at 12:06 P.M., Resident 109 was observed in the A hall dining room sitting against the wall in a chair, using a bedside table to eat lunch. During an interview on 1/8/19 at 10:06 A.M., LPN (Licensed Practical Nurse) 9 indicated Resident 109 scoots back in his seat, so staff placed him against the wall for safety reasons. LPN 9 was unaware of any documentation of this in the clinical record. 4. On 1/2/19 at 12:06 P.M., Resident 28 was observed in the A hall dining room sitting against the wall in a chair, using a bedside table to eat lunch. During an interview on 1/8/19 at 10:06 A.M., LPN 9 indicated Resident 28 sat away from the table per his own preference, as he did not like to be around other people. LPN 9 was unaware of any documentation of this in the clinical record. 5. On 1/2/19 at 12:13 P.M., Resident 1 was observed in the B hall dining room sitting against the wall in a chair, using a bedside table to eat lunch. During an interview on 1/8/19 at 10:06 A.M., LPN 9 indicated the reason Resident 1 sat away from the table was he grabbed from other resident trays. LPN 9 was unaware of any documentation of this in the clinical record.		All facility management and our clinical team will be in-serviced on issues relative to this POC as they relate to dignity and resident rights. Moreover, provider will audit areas alleged to be deficient utilizing strategies noted below. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Willow Manor F550-20190109-1 (DME) Audit Tool for resident names on DME (without consent). Willow Manor F550-20190109-2 (Call Light Audits) Audit Tool to track performance improvement in responding to requests for assistance. Willow Manor F550-20190109-3 (Dining Room Observation) Audit Tool for ensuring resident dignity and respect are honored in the dining room at meal times. Willow Manor F550-20190109-4 (Respect for Dignity and Privacy) Audit Tool to document observation by unit managers of care provided residents in their rooms. Progress toward the successful completion of this POC will be	

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	During an interview on 1/8/19 at 11:38 A.M., LPN 3 indicated there is no documentation or care plans for Resident 109, Resident 28, or Resident 1 sitting away from the dining room tables by themselves. On 1/8/19 at 1:49 P.M., a nondated Care Plan policy was provided. The policy indicated "... Personnel who note the change of condition make written suggestions for Care Plan change and submit to Director of Nursing or Designee ... Update Care Plan as indicated ..." 6. During an observation on 1/8/19 at 8:25 A.M., RT 3 and LPN 8 entered Resident 56's room. RT 3 began preparing for tracheostomy care. The resident was sitting up in a wheelchair near the bedroom door. LPN 8 exited the room. Neither staff member closed the resident's door or drew the curtain for privacy. RT 3 replaced the inner cannula to the resident's tracheostomy and performed suctioning. LPN 8 reentered the room. RT 3 continued with tracheostomy and oral care. The resident door and curtain were left open throughout care. During record review on 1/7/19 at 10:30 A.M., Resident 56's most recent MDS (Minimal Data Set) dated 11/24/18 (quarterly assessment) indicated Resident 56's cognitive functioning was unable to be determined, the resident required extensive assistance with ADL's (Activities of Daily Living), and the resident had a tracheostomy. Resident 56's diagnoses included, but were not limited to; personal history of traumatic brain injury, cognitive communication deficit, dysphagia, and persistent vegetative state. Physician orders included, but were not limited to:		monitored using the *F550-20190109 Willow Manor Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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	change inner cannula to tracheostomy every day shift Tuesday and Thursday, change tracheostomy collar every day shift every Tuesday, tracheostomy care using sterile technique every shift, and tracheal suction every shift to clear secretions. Resident 56's care plan included, but was not limited to; a focus stating Resident 56 required skilled nursing care related to tracheostomy and traumatic brain injury. Interventions included; Resident 56 was totally dependent on staff for all care and the resident required total assistance for ADL's, doctor visits, family education, and privacy. During an interview on 1/8/19 at 2:00 P.M., LPN 8 indicated staff should either pull the privacy curtain or close the door when suctioning a resident or performing tracheostomy care. On 1/9/19 at 10:20 A.M., The DON (Director of Nursing) supplied an undated facility policy titled, Resident's Rights. The policy stated, "Each and every Resident of this facility has the following Rights: ...Privacy in a Resident's room and during bathing, medical treatment, and personal care." 3.1-3(t) 3.1-3(p)(2)			
F 0553 SS=D Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the			

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	planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.			
	Based on interview and record review, the facility failed to ensure care plan conferences were held on a regular basis, and residents could participate in care plan conference meeting for 3 of 3 residents reviewed for dementia care. (Resident H, Resident 73, Resident 61). Findings include: 1. On 1/7/19 at 10:10 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to: dementia, TBI (traumatic brain injury), and psychotic disorder.	F 0553	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. *How will other residents having*	02/08/2019

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	The most recent Annual MDS (Minimum Data Set) assessment, dated 11/21/18, indicated cognitive status could not be assessed, and wandering daily. Care plan meeting sheets indicated for the last 12 months, a meeting was held on 4/17/18 (resident refused to attend), and 11/26/18 (resident was not invited). An invitation for a care plan meeting was sent to the resident and family on 5/26/18, but no care plan meeting took place. During an interview on 1/9/19 at 9:57 A.M., the SSD (Social Services Director) indicated no one called back after the 5/26/18 care plan meeting invite, so a meeting was not held. She also indicated that Resident H only had 2 care plan meetings in the last 12 months. 2. On 1/8/19 at 9:13 A.M., Resident 73's clinical record was reviewed. Diagnoses included, but were not limited to: dementia with behavioral disturbance and psychosis. The most recent Quarterly MDS assessment, dated 12/4/18, indicated a severe cognitive impairment. Care plan meeting sheets indicated for the last 12 months, a meeting was held on 8/8/18 (resident was invited but did not attend), and 12/19/18 (resident was not invited - sheet indicated "memory unit"). No care plan meeting invite sheets could be located in the clinical record. During an interview on 1/9/19 at 9:57 A.M., the SSD indicated all residents are always invited to care plan meetings. If the resident does not understand, will document that they did not		*the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Social Services Directors to conduct a Facility Wide Audit regarding Care Conference to ensure they are being scheduled per regulations and develop a Calendar with Care Conferences once scheduled. Moreover, Social Services Directors will schedule Care Conferences on specific days of each week with attention paid to overlapping deadline windows in order to never miss a deadline. Social Services Directors to keep a Care Conference Log to ensure that residents/families were invited to participate in Care Conferences. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Social Services Directors and InterDisciplinary Team will be in-serviced on care conference requirements. Administrator or designee will review with Social Services Directors to ensure that Care Conferences are to meet deadlines &/or per regulatory compliance. *How will the corrective action(s) will be monitored to ensure the alleged deficient*	

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	understand on the care plan meeting sheet. 3. On 1/8/19 at 10:34 A.M., Resident 61's clinical record was reviewed. Diagnoses included, but were not limited to: psychosis, dementia with behavioral disturbance, Obsessive Compulsive Disorder, insomnia, and depression. The most recent Admission MDS assessment, dated 11/26/18, indicated a severe cognitive impairment. A care plan meeting invite was sent to Resident 61 and guardian on 1/15/18, but no care plan meeting took place. Care plan meeting sheets indicated for the last 12 months, a meeting was held on 3/6/18 (resident declined, guardian present via phone). No other care plan meeting sheets were located in the clinical record. During an interview on 1/7/19 at 11:00 A.M., the SSD indicated care plan meetings are to be held every 3 months. On 1/8/19 at 1:49 P.M., a nondated Care Planning policy was provided. The policy indicated "... The Care plan will be reviewed as follows: 1) Medicare A 0 days 5, 14, 30, 60 and 90 2) All other Residents-quarterly. 3) All Residents with changes in status-including after a period of hospitalization, changes in level of care, or change in condition-next scheduled care plan conference ... Resident, family, or legal representative must be invited to each care plan conference ..." A nondated Care Planning Conference policy was also provided, and indicated "... The Resident/responsible party are always invited to attend ... "		*practice will not recur, i.e., what quality assurance program will be put into place?* Social Service Directors will bring Care Conference Calendars & Care Conference Logs to Quality Assurance Meetings and review with all applicable department managers. Administrator or designee will monitor care conference compliance using the *Willow Manor F553 – 20190109* Care Conference Schedule Audit Tool during normal business days daily for one month, weekly for 4 weeks and semi-monthly for four months for a total of 6 months. Compliance relative to this alleged deficient practice will be reviewed in the Willow Manor Quality Assurance and Performance Improvement (QAPI) meeting monthly or until substantial compliance is reached.	

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F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach and easily accessible for 3 of 3 residents reviewed for accommodation of needs and 1 of 31 rooms reviewed during the initial pool. (Resident 76, Resident 35, Resident 85, Room 3) Findings included: 1. During observations on 1/2/19 at 10:02 A.M. and 10:25 A.M., Resident 76 was observed sitting in his recliner and his call light was not within reach. The call light was attached to his bedside rail and hanging to the floor. During an observation and interview on 1/2/19 at 10:30 A.M., LPN 20 indicated Resident 76 was not able to transfer himself and he needed the assistance of two staff persons. LPN 20 further indicated Resident 76's call light needed to be clipped to his recliner. LPN 20 removed the call light cord and button from the bedside rail and clipped it to the resident's recliner. The clinical record for Resident 76 was reviewed on 1/4/19 at 10:00 A.M. The record indicated Resident 76's diagnoses included, but were not limited to, depression and Huntington's disease.	F 0558	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. It is the policy of this provider to ensure call lights are within reach and easily accessible at all times when resident is not directly observed in the residence, bathroom and/or public / common areas. Those found to be affected by the alleged deficient practice were addressed immediately. A whole house audit of every call light button and pull cord to ensure there is nothing preventing it from being within resident reach and easily accessible in residences, bathrooms and/or public / common areas. All staff will be	02/08/2019

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	The Quarterly MDS (Minimum Data Set) assessment, dated 12/8/18, indicated Resident 76 was cognitively impaired. The assessment further indicated Resident 76 required the assistance of two staff for bed mobility, transfers, and toileting. 2. During observations on 1/2/19 at 10:03 A.M. and 10:35 A.M., Resident 85 was observed lying in bed and her call light was on the floor at the head of her bed. During an interview and observation on 1/2/19 at 10:35 A.M., LPN 14 indicated Resident 85 needed assistance with transfers and that she should use the call light to call for staff before getting out of bed. LPN 14 picked the call light up from the floor and placed it on Resident 85's bed. The clinical record for Resident 85 was reviewed on 1/3/19 at 11:00 A.M. The record indicated Resident 85's diagnoses included, but were not limited to, anxiety, depression, and dementia. The Annual MDS (Minimum Data Set) assessment, dated 11/6/18, indicated Resident 85 was cognitively impaired. The assessment further indicated Resident 85 required the assistance of two staff for bed mobility, transfers, and toileting. 3. During observations on 1/2/19 at 10:05 A.M. and 10:39 A.M., Resident 35 was observed lying in bed with her eyes closed and her call light was located under the bed and outside of her reach. During an interview and observation at 10:39 A.M., LPN 14 indicated Resident 35 used her call light, needed assistance with transfers and that the call light should have been within reach. LPN 14 reached under the bed, pulled the call light		educated on policies and procedures with respect to call lights being within reach and easily accessible in residences, bathrooms and/or public / common areas. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* It is the policy of this provider to ensure call lights are within reach and easily accessible at all times when resident is not directly observed in the residence, bathroom and/or public / common areas. In order to ensure no one is found to be affected by the alleged deficient practice, a whole house audit of every call light button and pull cord to ensure there is nothing preventing it from being within resident reach and easily accessible in residences, bathrooms and/or public / common areas. All staff will be educated on policies and procedures with respect to call lights being within reach and easily accessible in residences, bathrooms and/or public / common areas. *What measures will be put into place and what systemic changes will be made to ensure*	

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	155042	A. BUILDING 00 B. WING	01/09/2019

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	button out, and clipped it to the resident's bed. The clinical record for Resident 35 was reviewed on 1/3/19 at 11:00 A.M. The record indicated Resident 35's diagnoses included, but were not limited to, anxiety, depression, dementia, and cerebrovascular accident. The Quarterly MDS (Minimum Data Set) assessment, dated 11/7/18, indicated Resident 35 was cognitively impaired. The assessment further indicated Resident 35 required the assistance of one staff for bed mobility, transfers, and toileting. During an interview on 1/9/19 at 11:45 A.M., the Administrator indicated it was the facility's policy to ensure all call lights were within reach of the residents at all times. 4. On 1/4/19 at 2:03 P.M., the shared bathroom in room 3 was observed with the call light string wrapped around a grab bar, and dragging the floor. The bathroom was shared by three residents. On 1/9/19 at 10:50 A.M., the shared bathroom in room 3 was observed with the call light string wrapped around a grab bar, and dragging the floor. During an interview at this time, LPN 21 indicated the string is not supposed to be wrapped around the grab bar, or dragging the floor. During an interview on 1/9/19 at 11:00 A.M., the Maintenance Supervisor indicated the bathroom call light strings were not supposed to be wrapped around the grab bar, but draped over them as to not touch the floor. Staff is supposed to hand the string to the resident while on the toilet and place it back when they are finished. He also indicated staff was aware of this, and did not		*that the alleged deficient practice does not recur?* Room Rounds are done routinely by the InterDisciplinary Team (IDT) every day. Checking the placement of call lights and ensuring call lights are placed within reach and easily accessible is a key part of the Room Rounds process. Every employee entering a resident's room will know to place call lights within reach and ensure they are easily accessible before leaving the room. All staff will be in-serviced regarding this requirement. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* The Willow Manor F558 – 20190109 Audit Tool will document whole house call light checks on regular business days for one month, Progress toward the successful completion of this POC will be monitored using the *Willow Manor F558-20190109 Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL	

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	know why the string was wrapped around the grab bar. On 1/8/19 at 1:48 P.M., an undated Call Light policy was provided. The policy indicated "... The call light must remain functional and within reach of the Resident ..." 3.1-3(v)(1)		BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance of call lights within the reach of residents and easily accessible. The Administrator and/or designee will review the audit tool for compliance daily during regular business days. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0574 SS=E Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(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			

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	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 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.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established			

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	under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (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. Based on observation, interview and record review, the facility failed to successfully inform residents about how to file a grievance. Resident Council members indicated during the Resident Council Meeting that they were unaware of how to file a grievance and that the Notice of Grievance and procedures information was posted too high for residents to read during 3 of 6 days during the survey. (Resident 23, Resident 51, Resident 91, Resident 36, Resident 52) Findings included: During observations on 1/2/19 at 1:25 P.M. and 1/3/19 at 8:50 A.M., the posting for reporting a grievance was located in the lobby of the main floor. The posting for the phone numbers of the Indiana State Department of Health and the Ombudsman were above head level for an adult of average height. During the Resident Council Meeting on 1/3/19 at 9:05 A.M., Resident 23, Resident 51, and Resident 91, indicated they did not know where the posting	F 0574	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provide to ensure that federal participation requirements for nursing homes participating in Medicare and/or Medicaid programs are met in accordance with federal and state law. When identified the required notices and contact information were too high to be accessible by all residents residing in the facility, the required notices and contact information postings were lowered in order to be accessible by all. In addition, facility reproduced the required notices and contact information postings and posted an additional 8 copies at accessible levels at all entrances	02/08/2019

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	for the Indiana State Department of Health and the Ombudsman phone numbers were located in the event they wanted to make a complaint or file a grievance. Resident 36 and Resident 52 indicated they could not get to the phone numbers because they could not wheel their wheelchairs up the ramp from the basement to the main floor. The residents said they required the assistance of a CNA to push their wheelchairs up to the location. Resident 36 indicated knowledge of where the posting for the Indiana State Department of Health and Ombudsman's numbers were located, but the posting was positioned too high for residents in wheelchairs to read the numbers. Resident 36 indicated the phone number should be available to all residents on all the floors of the facility. During an interview on 1/3/19 at 11:34 A.M., Resident 58 indicated the posting for Indiana State Department of Health and the Ombudsman's phone numbers were located too far away for him to have access to them. Resident 58 indicated he rarely got out of bed, but whenever he did need to get out of bed, he needed the assistance of 2 staff. He indicated he was unable to go upstairs and read the numbers. He said he wanted to have the numbers accessible to him and other residents on the first floor. The Resident Council Minutes, dated 11/27/18, were provided by the Activities Director on 1/2/19 at 10:45 A.M. The Resident Council Minutes read as follows: "...Ombudsman/Compliance Hotline...Corporate Compliance Hotline #[phone number]...We also reviewed that they can call and talk to the Ombudsman...and what she does for the residents..." The Resident Council Minutes lacked documentation of the location of Ombudsman		and other public locations in the facility both above and below the ramp in the Activities room. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* In addition to the steps taken in #1 above, the required notices and contact information will be added to the admission packet and in greater detail in Resident Council minutes. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An 8.5" X 11" posting containing required notices and contact information has been produced for each resident currently located in the facility. Documentation of receipt will be kept in the resident file. The required notices and contact information will be added to the admission packet and will be added in greater detail in all Resident Council minutes going forward. required notices and contact information postings and posted an additional 8 copies at accessible levels at all entrances and other public locations in the facility both above and below the	

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	contact information and the information about how to contact the state in order to file a complaint about the care they received. During an interview on 1/3/19 at 1:22 P.M., the Administrator indicated he was aware the posting should be accessible to all residents. During an interview on 1/4/19 at 8:31 A.M., the Administrator indicated he would post the contact information for the Indiana State Department of Health and Ombudsman at a height that was viewable for residents in a wheelchair and that the information would be posted on all the halls of the facility. He indicated the facility did notify residents about how to file a grievance with the State and Ombudsman during the Resident Council Meetings, but not all residents attended the meetings. The Administrator further indicated that, even though there was no written policy for posting the information, it was the facility's policy to make the information accessible to all residents in the building. 3.1-7(a)(3)(b)		ramp in the Activities room. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* All residents will receive an 8.5" X 11" posting with the required notices and contact information and will sign documentation to that effect.	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse			

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	or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of sexual abuse was reported to the state survey agency for 1 of 1 sexual abuse allegations reviewed. (Resident E) Findings include: On 1/7/19 at 8:51 A.M., the facility grievances were reviewed. A note, dated 7/19/18 at 12:55 P.M., included, but was not limited to: "I entered res [resident] [name of resident] room after picking up her tray I offered to do her PROM [passive range of motion]. While giving res PROM res began venting to QMA [qualified medication aide]. Res stated 'a male nurse was sexually inappropriate with her by patting her bottom after getting her off the bed pan'. QMA asked her if she would like to speak with the administer [sic]. Res said 'Yes'. Res began venting more about not getting call lights answered not getting PROM done. QMA left room after finishing care. QMA	F 0609	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The policy entitled “REPORTABLE INCIDENT POLICY AND ISDH REPORTABLE UNUSUAL OCCURRENCE POLICY” was reviewed and all management personnel were in-serviced on the requirements and expectations of said policy. It is the practice of this provider to follow this policy to	02/08/2019

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	went to let the administer [sic] know. Administer [sic] was out of the building. QMA knocked and entered res room. QMA said 'The administer [sic] is out but I left word with his assistant' QMA informed res that the DON was available She said 'No because [name of DON] is a waste of space' she said 'I have talked to [names of Wound Nurse, Social Worker, and DON] and they brought in a clipboard and did nothing' 'The male nurse played with my hair and other res are worried about him and won't allow him in their room.' 'I reported to [name of nurse] and she told [name of wound nurse] and [name of wound nurse] yelled and screamed at [name of nurse] to 'Leave [name of alleged sexual impropriety nurse] alone' 'So there is no point in telling them they won't do anything'.....QMA reported to DON, ADON, Social services..... On 1/7/19 at 1:37 P.M., the Administrator indicated the allegation of sexually inappropriateness should have been reported. On 1/2/19 at 11:00 A.M., the DON provided the "Abuse and Neglect" policy, revised 8/5/16. The policy included, but was not limited to: The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law. 3.1-28(c)		the letter. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* The policy entitled “REPORTABLE INCIDENT POLICY AND ISDH REPORTABLE UNUSUAL OCCURRENCE POLICY” was reviewed and all management personnel were in-serviced on the requirements and expectations of said policy. It is the practice of this provider to follow this policy to the letter. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Discussion related to “REPORTABLE INCIDENT POLICY…” will be added to the Willow Manor StandUp (Morning Meeting) agenda and covered during all StandUp or Morning Meetings. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Discussion related to	

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			"REPORTABLE INCIDENT POLICY…" will be added to the Willow Manor StandUp (Morning Meeting) agenda and covered during all StandUp or Morning Meetings.	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of			

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	services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 0645	*What corrective action(s) will*	02/08/2019

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	Based on observation, interview, and record review, the facility failed to ensure a resident received a pre-admission screening and resident review (PASRR) for 1 of 2 residents reviewed for PASRR. (Resident 4) Findings include: On 1/4/19 at 9:23 A.M., Resident 4's clinical record was reviewed. The Annual MDS (Minimum Data Set) assessment, dated 6/4/18, and the Quarterly MDS assessment, dated 10/3/18, indicated Resident 4 experienced no cognitive impairment. The assessment further indicated Resident 4 required the assistance of 2 staff for transfers, and had diagnoses of anxiety, depression, and bipolar disease. The annual MDS also indicated Resident 4 had not been evaluated for a PASRR level 2 The Physician's orders included, but were not limited to: 11/2/18: Seroquel tablet (an antipsychotic medication). Give 500 mg (milligrams) by mouth at bedtime for Bipolar Disorder. 11/2/18: Discontinue Seroquel tablet. Give 400 mg by mouth at bedtime for mood. 11/2/18: Seroquel tablet. Give 100 mg by mouth one time a day for mood. 11/8/18: Venlafaxine HCl tablet (an antidepressant medication). Give 75 mg by mouth two times a day for depression. 11/8/18: Discontinue Venlafaxine HCl tablet. Give 125 mg by mouth two times a day for depression. During an interview on 1/8/19 at 9:23 A.M., the Social Services Director (SSD) indicated Resident 4 had been a resident at the facility until 2013. Resident 4 moved to another nursing facility in 2013, but then was readmitted to this facility in		*be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Social Services Directors will ensure PASSRR requirements have been met on Resident 4 still currently residing in the facility. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Social Services Directors to conduct a Facility Wide Resident Audit to ensure PASSRR requirements have been met on all residents requiring a Level 2 currently residing in the facility. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Administrator or designee will in-service Social Services Directors on PASSRR requirements to ensure they are	

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	2014. The SSD indicated that Resident 4 missed having a PASRR when she was readmitted in 2014. The SSD indicated they had completed the paper work, but the completed forms were never sent to the agency. The SSD indicated she was unsure if Resident 4 needed a PASRR level 2, but would send the information necessary to find out what was needed. The SSD indicated Resident 4 had received additional mental illness diagnoses since 2014. A Diagnoses List was provided by the SSD on 1/8/19 at 10:00 A.M., and it indicated Resident 4 was diagnosed with anxiety disorder 1/2/17, major depression 8/17/16, and Bipolar disorder 8/17/16. During an interview on 1/8/19 at 9:40 A.M., the Administrator indicated the facility followed the federal guidelines and the state guidelines for Preadmission Screening and Resident Reviews. A policy "...PASRR Level 1...provider Policy & Procedure..." was provided by the Social Services Director on 1/8/19 at 10:30 A.M., and read as follows: "...Per federal requirement, every person who is seeking admission to a Medicaid-certified NF must be screened for the presence of a MI, ID or condition before the provider can admit him or her...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		completed per regulation going forward and facility is in compliance. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Willow Manor F645-20190109 Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance of call lights within the reach of residents and easily accessible. The Administrator and/or designee will review the audit tool for compliance daily during regular business days. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or	

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			designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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			

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	future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was updated with personalized and effective interventions for contact isolation precautions for 1 of 1 reviewed for isolation precautions. (Resident 162) Findings include: During an observation on 1/7/19 at 10:35 A.M., Resident 162 was observed lying in bed with their eyes closed. There were two uncovered receptacles with red trash bag liners, one containing trash, and the other containing soiled laundry. No signage was posted on the door informing anyone to consult nurses before entry. The clinical record for Resident 162 was reviewed on 1/7/19 at 10:40 A.M. The record indicated Resident 162's diagnoses included, but were not limited to, urinary tract infection with VRE (strain of bacteria that can cause infection), diabetes, and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 12/4/18, indicated Resident 162 experienced cognitive impairment. The assessment further indicated Resident 162 required the assistance of two staff for bed mobility, transfers, and toileting.	F 0656	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Care plan for Resident 162 was corrected to accurately reflect the type of contact isolation precaution(s) should be followed. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* A whole house audit of residents on contact isolation was conducted and (where found) care plans were corrected to accurately reflect the type of contact isolation precaution(s) should be followed.	02/08/2019

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	A care plan for Resident 162 "...VRE in the urine..." dated 1/5/19 read as follows: "...Always follow Standard Precautions protocols...Follow approximated precautions: Airborne...Contact...Droplet..." The care plan lacked documentation what type of isolation precaution should be followed. A physician's order dated 1/5/19 read as follows: "...contact isolation d/t [due to] VRE in urine..." During an interview on 1/9/19 at 8:49 A.M., the Unit Manager for E and F hall (UM) indicated Resident 162 was admitted with VRE in her urine and needed to be on contact isolation. The Unit Manager indicated the care plan for VRE should have been more person centered and identified contact isolation as the type of isolation precaution that should have been followed. During an interview on 1/7/19 at 11:06 A.M., the Administrator indicated it was the policy of the facility to identify the type of isolation the resident needed to all staff in the facility. 3.1-35(a)		*What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* MDS developed/revised the Care Plans related to Infections/Contact Isolation. Residents with Infections/Contact Isolation will be assigned Care Plans for both. Admission Packet has been updated to include a form to identify if resident is on isolation, and, if so, properly identify Contact, Droplet, or Airborne isolation precautions. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* MDS to conduct Care Plan Audits to ensure all Resident Care Plans accurately reflect their individualized plan of care. Progress toward the successful completion of this POC will be monitored using the *F656-20190109 Willow Manor Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for	

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			ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards for 2 of 5 residents reviewed for falls and 2 of 5 resident rooms on the GHI halls observed. Interventions to prevent falls were not in place and water temperatures in resident bathrooms reached 125 degrees Fahrenheit. (Resident E, Resident G, Resident D, Resident F) Findings include:	F 0689	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state	02/08/2019

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	1. On 1/2/19 at 11:40 A.M., Resident E indicated her left side was weak. Resident E indicated she had been able to transfer with a sit to stand mechanical lift until the Christmas holiday when she injured her right ankle. Resident E indicated she had not been out of bed since she injured her right ankle, because she could not use the sit to stand mechanical lift. On 1/4/19 at 1:32 P.M., Resident E indicated that on 1/2/19 facility staff was in a hurry to place a new mattress on her bed. Resident E indicated she told the CNA's she was unable to use the sit to stand mechanical lift because she had injured her right foot trying to visit family over the Christmas holiday. Resident E indicated that instead of utilizing the full mechanical hoyer lift the CNA's attempted to transfer her without a mechanical lift. Resident E indicated her legs gave out and she was lowered to the ground but did hit the floor a little. Resident E indicated she had broken her knee in the fall. On 1/8/19 at 9:58 A.M., Resident E's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 11/17/18, indicated Resident E had no cognitive impairment, required extensive assistance of two persons for transfer, and was only able to stabilize during a surface to surface transfer with the assistance of staff. The Care Plans included, but were not limited to: Potential for falls related to difficulty walking, muscle weakness, and lack of coordination, initiated on 6/3/17. The interventions included, but were not limited to, Hoyer lift for all transfers, initiated on 1/2/19. The CNA assignment sheets, dated 12/31/18,		law. Fall Interventions: InterDisciplinary Team – Clinical Management, Therapy, MDS, and SS will review Incident Reports/Falls each weekday during Clinical Meeting. Nursing Management & Therapy will notify floor team verbally and in writing of interventions & Update CNA Assignment Sheets, when applicable. H2O Temperatures in Resident Bathrooms: facility wide water temperature checks per preventive maintenance schedule. *H2O Temperature Audit each unit per maintenance. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Fall Interventions: InterDisciplinary Team – Clinical Management, Therapy, MDS, and SS will review Incident Reports/Falls each weekday during Clinical Meeting. Nursing Management & Therapy will notify floor team verbally and in writing of interventions & Update CNA Assignment Sheets, when applicable. H2O Temperatures in Resident Bathrooms: facility wide water temperature checks per preventive maintenance schedule. *H2O Temperature Audit each unit per maintenance.	

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	indicated Resident E required a sit to stand mechanical lift for transfers. The Progress Notes included, but were not limited to: 12/24/18 at 5:00 P.M.: Resident was going to go on leave with son, assisted into wheelchair and taken out to his car. When she started to transfer into the car her right ankle popped badly and she complained of right ankle pain..... 1/2/19 at 8:37 P.M.: Earlier a little after 5:00 (name of two CNA's) attempted to manually transfer assist of two using gait belt. When lowering into chair, resident was ill postured and slid forward, CNA's attempted to ease to floor. CNA report gently easing to floor. Resident reports impact with floor and reported left hip pain after returning to bed....Resident did not want to wait for mobile x-ray and stated analgesia was insufficient and wanted to go to hospital..... 1/2/19 at 11:00 P.M.: Resident returned from (name of hospital) with immobilizer to left knee and leg. Report from (name of hospital) indicated a broken knee. A Radiology Report, dated 1/2/19, included, but was not limited to: Findings: There is a fracture involving the lateral femoral condyle (knee). The bones are severely osteopenic. On 1/8/19 at 10:31 A.M., the DON indicated she was unsure why the staff did not utilize the sit to stand mechanical lift. The DON indicated she knew Resident E had twisted her ankle the prior week but did not know if she was not able to use the sit to stand. The DON indicated she felt like it was a judgement call whether the CNA's should have used a full mechanical lift for the transfer. The DON further indicated they did order		*What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* In-service: Incident Reports/Falls P&P and Packets (Nurses) In-service: Water temps (Maintenance) Fall interventions Audits on each unit: fall information, interventions, therapy/floor staff notified, CNA assignment sheets updated. Water temperature audits throughout building through Preventive Maintenance program. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Willow Manor F689-20190109 Water Temps Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance of	

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	Resident E to be transferred with a full mechanical lift from this point forward. 2. On 1/4/19 at 9:39 A.M., a loud noise was heard coming from the dining room. Someone yelled for a nurse to come to the dining room. Resident G was observed to be lying on the floor beside a wheelchair. Resident G indicated he was trying to sit on the sofa in the common area. Resident G was observed to have regular white socks on. LPN 15 returned to the nursing station and indicated Resident G was trying to self transfer from the wheelchair to the sofa and fell. LPN 15 indicated Resident G had regular socks on. On 1/4/19 at 9:45 A.M., Resident G's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 12/20/18, indicated Resident G had severe cognitive impairment and required extensive assistance of two persons for transfers. The Care Plans included, but were not limited to: Potential or falls related to difficulty walking, lack of coordination, and muscle weakness, initiated on 9/27/18. The interventions included, but were not limited to: Ensure the resident is wearing proper footwear when ambulating or mobilizing in wheelchair, initiated on 9/27/18. Do not leave in wheelchair in room, assist resident to bed or recliner, initiated on 10/29/18. On 1/8/19 at 10:00 A.M., the Incident/Accident reports for Resident G were reviewed. 10/29/18 at 8:05 A.M.: Resident yelling out from room, upon entering resident had wheelchair next to bed and had upper half of body on bed with legs hanging off bed.....new intervention, do not leave in wheelchair in room, either place in bed or recliner		call lights within the reach of residents and easily accessible. The Administrator and/or designee will review the audit tool for compliance daily during regular business days. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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	11/17/18 at 10:30 A.M.: Patient found laying on floor in room. Patient slid out of chair while trying to reach for urinal....new intervention, therapy staff to obtain assignment sheet with fall interventions before treating patients on rehab unit.... 1/4/19 at 9:45 A.M.: Resident stated transferring self from wheelchair to couch in day area.... new intervention, bell given to resident when not in room, gripper socks.... On 1/8/19 at 10:51 A.M., the DON indicated after Resident G's fall on 10/29/18 the intervention was to not leave the resident in his wheelchair in room. The DON indicated that Resident G had been left up in his wheelchair by therapy which resulted in a fall on 11/17/18. The DON further indicated that proper footwear would include, but was not limited to gripper socks or shoes. The DON indicated during Resident G's fall on 1/4/19, Resident G was wearing regular tube socks. On 1/9/18 at 8:24 A.M., the DON provided the "Fall Management" policy, revised 11/2014. The policy included, but was not limited to: The Interdisciplinary team (IDT) evaluates each resident's fall risks. A plan of care is developed and implemented based on this evaluation with ongoing review. If a fall occurs the IDT conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls.... 3. During an interview with Resident F on 1/3/19 at 10:10 A.M., the resident indicated the water in the bathroom was too hot and that it had to be adjusted or it would burn you. During an observation on 1/3/19 at 1:33 P.M., Resident F's water from the bathroom sink reached a measured temperature of 125 degrees Fahrenheit.			

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	During record review on 1/4/19 at 9:10 A.M., Resident F's most recent MDS dated 11/29/18 (quarterly assessment) indicated the resident had mild cognitive impairment and required extensive assistance for transfers and toilet use. Resident F's diagnoses included, but were not limited to; adjustment disorder with depressed mood, and repeated falls. Resident F's care plan included, but was not limited to; a focus on falls with interventions including; encourage resident to be compliant with limitations and to ask for assistance as needed, and the resident needs a safe environment with even floors and free of spills. 4. During an observation of Resident D's room and bathroom on 1/3/19 at 1:45 P.M., the resident's water from the bathroom sink reached a measured temperature of 125 degrees Fahrenheit. During record review on 1/4/19 at 9:40 A.M., Resident D's most recent MDS (Minimal Data Set) dated 12/12/18 (admission assessment) indicated the resident had mild cognitive impairment and required extensive assistance for transfers and toilet use. Resident D's diagnoses included, but were not limited to; unspecified dementia with behavioral disturbances and cognitive communication deficit. Resident D's care plan included, but was not limited to; a focus of Resident D being deemed an elopement risk with a goal that Resident D will remain safe in the facility. During an interview on 1/3/19 at 1:55 P.M., CNA			

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	14 indicated that the water in resident bathrooms is sometimes too hot. CNA 14 had noticed before on multiple halls. Indicated having to adjust the water on the sink for the residents so it didn't get too hot. During an interview on 1/4/19 at 11:01 A.M., M 2 and M 5 (Maintenance) indicated water temperatures are checked once a week on every hall. They choose one room on a hall and try to choose different rooms every week to check. M 2 and M 5 indicated having to clean out a mixer and were checking temperatures every hour to ensure water temperatures were in range. If there was a concern with water from staff, a work order could have been filled out or they could be reached any time for an emergency. M 2 and M 5 indicated not being aware of any hot water complaints and had no previous work orders to address hot water before the previous day. During an interview on 1/4/19 at 1:49 P.M., CNA 14 indicated having reported hot water in resident bathrooms to nursing staff in the past. On 1/8/19 at 9:21 A.M., the DON (Director of Nursing) supplied an undated facility policy titled, "Test and log the hot water temperatures." The policy stated, "Ensure patient room water temperatures are between... Indiana - 100 - 120 [degrees Fahrenheit]" A hand written note to the side of the policy listed a range between 105 - 120 degrees Fahrenheit in Indiana. This Federal tag relates to Complaint IN00283004. 3.1-45(a)(1) 3.1-45(a)(2)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure that appropriate treatment and services were provided	F 0690	*What corrective action(s) will be accomplished for those residents found to have been*	02/08/2019

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	for incontinence and catheter care for 2 of 8 residents observed for care an 1 of 2 residents reviewed for urinary tract infections. Residents were observed saturated and catheter bag and tubing were left on the floor. (Resident J, Resident H, Resident D) Findings include: 1. On 1/7/19 at 1:10 P.M., Resident J was observed sitting in the dining area with foul odor, and a discolored stain on the back of her sweater. CNA 10 assisted Resident J to the bathroom. CNA 10 cleaned up a bowel movement from Resident J, and helped put on a new brief and set of clothes. On 1/7/19 at 1:45 P.M., Resident J's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 11/11/18, indicated cognitive status could not be assessed, resident was not on a toileting program, was frequently incontinent of urine, always incontinent of bowel, and required extensive assistance of 1 for toileting. A current care plan for bladder incontinence, dated 5/12/17, included, but was not limited to the intervention "Check the resident every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes" 2. On 1/2/19 at 11:53 A.M., Resident H was observed in the common area with the back of their pants saturated. During a continuous observation on 1/8/19, the following was observed: 9:05 A.M., Resident H was sleeping in the common area in a chair.		*affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Resident care plans were updated to clarify proper catheter care *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* UTI's, Incontinence (Residents Saturated), F/C Bag & Tubing on floor: DON to monitor UTI's each month per Unit Manager's Monthly Infection Logs and report findings to QAPI Committee. Unit Managers to review residents with incontinence to determine if appropriate interventions are in place (toileting schedule). Incontinence/Foley Cath Audits will be conducted on each unit. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* In-service nursing team: incontinence/Foley catheters/UTI	

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	10:44 A.M., Resident H was sleeping in the common area in a chair. 10:59 A.M., CNA 10 was observed walking past Resident H to assist another resident to the bathroom. 11:15 A.M., Resident H woke up, and scooted to the edge of the chair. 11:23 A.M., Resident H got up and was directed to the dining area by LPN 9. 11:26 A.M., Resident H walked back to the common area and sat on a chair. 11:41 A.M., Resident H was directed to sit in another chair across the room by LPN 9. 11:50 A.M.. Resident H was asked if he needed to use the restroom, and declined. On 1/7/19 at 10:01 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to dementia, TBI (traumatic brain injury), and psychotic disorder. The most recent Annual MDS assessment indicated cognitive status could not be assessed, Resident H was not on a toileting program, was frequently incontinent of urine, always incontinent of bowel, and required extensive assistance of 1 for toileting. A current care plan for bladder incontinence, dated 12/13/17, included, but was not limited to the intervention "Assist resident with toileting every 2 hours and PRN" During an interview on 1/8/19 at 11:58 A.M., LPN 9 indicated Resident H was frequently incontinent, and needed to be taken to the restroom every 2 hours. On 1/8/19 at 1:49 P.M., an undated Bowel and Bladder Assessment/Retraining policy was		(nurses, QMAs, CNAs). DON to monitor UTI's each month per Unit Manager's Monthly Infection Logs and report findings to QAPI Committee. Unit Managers to review residents with incontinence to determine if appropriate interventions are in place (toileting schedule). Weekly incontinence/Foley catheter audits will be conducted on each unit. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* See Above – DON QAPI Report (UTIs), residents with incontinence review interventions, and incontinence/Foley catheter audits per POC. Progress toward the successful completion of this POC will be monitored using the *Willow Manor F690-20190109 Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance.	

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	provided. The policy indicated "...The Resident is check by caregivers on a regular basis and asked to report verbally if wet or dry ... The Resident is asked (prompted) to try to use the toilet ..." 3. During an observation on 1/2/19 at 12:19 P.M., Resident D's catheter bag and catheter tubing were resting on the dining room floor during lunch. During an observation on 1/3/19 at 1:08 P.M., Resident D's catheter bag was resting on the dining room floor. During an observation on 1/7/19 at 10:42 A.M., Resident D's catheter tubing was observed resting on the floor of the resident's room. During record review on 1/4/19 at 9:40 A.M., Resident D's most recent MDS (Minimum Data Set), dated, 12/12/18 (admission assessment), indicated the resident had mild cognitive impairment, required extensive assistance with transfers, bed mobility, and toilet use, and had an indwelling catheter. Diagnoses included but were not limited to; benign prostatic hyperplasia with lower urinary tract symptoms, chronic kidney disease, and unspecified dementia. Physician orders included, but were not limited to; catheter (flush weekly), change Foley catheter bag every night shift on the 15th of each month, change Foley catheter on the 15th of each month, Foley catheter care every shift for infection control, urinary analysis and urine culture for cloudy urine and elevated temperature (12/27/18), and Cipro (an antibiotic medication) 500 mg (milligrams) for UTI (12/27/18).		The Administrator and/or designee will review the audit tool for compliance daily during regular business days. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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	Resident D's care plan included, but was not limited to; UTI, indwelling catheter with interventions including catheter care (per policy) every shift, and self care deficit with a goal stating the Resident's ADL (Activities of Daily Living) needs will be met by staff with assistance from the Resident as tolerated. During an interview on 1/7/19 at 1:16 P.M., LPN 8 indicated catheter care included performing perineal care, emptying catheter bags, keeping catheter bags covered, and keeping catheter bags and tubing off the floor. On 1/8/19 at 9:21 A.M., the DON (Director of Nursing) supplied an undated facility policy titled, "Catheter Care, Foley". The policy stated, "Foley catheter care will promote good hygiene and reduce the potential for infection." This Federal tag relates to Complaint IN00283004. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident			

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	preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure a therapeutic diet was served to a resident for 1 of 4 residents reviewed for nutrition. (Resident 52) Findings include: On 1/3/19 at 10:55 A.M., Resident 52 indicated she was on a special diet but did not receive the special diet from the kitchen. On 1/8/19 at 9:33 A.M., Resident 52's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 11/15/18, indicated Resident 52 had no cognitive impairment and received a therapeutic diet. The Physicians Orders included, but were not limited to: Months 4-6. Breakfast two ounces of protein and two ounces of starch. Lunch two ounces of protein and two ounces of fruit. Dinner two ounces of protein and two ounces of vegetable until 1/13/19. On 1/8/19 at 11:44 A.M., Resident 52's noon meal tray was observed. The tray had a full serving of ham, green beans, and potatoes. On 1/9/19 at 9:11 A.M., the Dietary Manager indicated the ham was 4.5 ounces, green beans were 4 ounces an the potatoes were 4 ounces.	F 0692	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Dietary and nursing staff were in-serviced and the dietary order for the affected resident was provided the remainder of her stay at the facility. Resident was re-educated regarding making good choices relative to her diet order. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Nursing and Dietary management have conducted a whole house audit to ensure Dietary department is aware and preparing all dietary orders per plan of care and nursing	02/08/2019

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	The Dietary Manager indicated she was aware Resident 52 had a special diet but the cook on the previous day was new and Resident 52 had gotten a regular tray. The Dietary Manager indicated at lunch Resident 52 was supposed to get two ounces of protein and two ounces of fruit. On 1/9/19 at 10:43 A.M., the DON provided the "Therapeutic and Mechanically Altered Diets" policy, dated 6/2018. The policy included, but was not limited to: The kitchen staff prepares and serves all therapeutic and mechanically altered diets as planned.... 3.1-46(a)(2)		is aware that diet orders are delivered to table and/or room as ordered. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Dietary Manager to in-service staff regarding Therapeutic & Mechanically Altered Diets and Diet Spreadsheets. Dietary and nursing departments will be in-serviced per policy and audit mechanism(s) reviewed accordingly. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Willow Manor F692-20190109 Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance of diet order being executed as	

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			written. The Administrator and/or designee will review the audit tool for compliance daily during regular business days. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. 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). §483.35(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) of this section, licensed nurses; and			

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	(ii) Other nursing personnel, including but not limited to nurse aides. §483.35(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. Based on observation, interview, and record review, the facility failed to ensure staffing was adequate to prevent falls for 2 of 8 residents who met the criteria for review of accidents, and were unable to meet the needs of the residents for 10 of 13 confidential resident interviews, on 3 of 4 nursing units, in a facility census of 113. Findings include: 1. During the survey period of 1/2/19 through 1/9/19, the following comments were made while random confidential interviews were conducted: a. A staff member indicated there is not enough staff to sufficiently care for the residents in the facility. If one resident required more than one staff member, they either would have to wait for care, or other residents would have to wait while they went to care for that resident. b. A staff member indicated one nurse for 2 halls and one aide per hall is not enough staff because of the amount of care the residents required. Normally this staff member could not get ice passed to all residents because of the short amount of staff. Two hour checks could not be completed on time, and some residents have sat in urine waiting for staff. c. A staff member indicated many times had to stay after the shift to document because there was no time during the shift to do so.	F 0725	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. HR Team Members (Clinical Management, Administrator, Human Resources Director, Scheduler) will review the unique characteristics of each unit regarding resident census, acuity and level of care needed in establishing staffing ratios (staffing expectations/minimums per unit per shift). *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* HR Team Members (Clinical Management, Administrator,	02/08/2019

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	d. A resident indicated a couple of weeks ago, there was a 59 minute wait before a CNA responded to the call light. While waiting, this resident had a bowel movement in his pants. He indicated when a CNA answered the call light, she told him that was the way it was whenever you had to take care of 40 people. The resident indicated many times it took longer than 30 minutes to get a CNA to respond to a call light. e. A resident indicated that CNAs responded to his call light, but they would turn it off and say they would be right back. The resident indicated he was lying there, needed to be cleaned up, and he would have to wait an average of 15 to 30 minutes. The resident indicated that call lights might be sounding, but that he could hear staff at the nurses' station talking and laughing. The resident indicated that staff were sometime talking on their telephones. f. A resident indicated CNAs had let call lights ring, and walk past their rooms on their cell phones ignoring the call light. g. A resident indicated she had waited more than 45 minutes for her call light to be answered, and a CNA would come into the room, turn off the call light, and leave again with no explanation. h. A resident indicated it takes a while for staff to respond to call lights. i. A resident indicated several times he had to make his own bed, and fill sugar bowls in the dining room because the staff are on their cell phones. j. A resident indicated they had to wait 25 minutes		Human Resources Director, Scheduler) will review the unique characteristics of each unit regarding resident census, acuity and level of care needed in establishing staffing ratios (staffing expectations/minimums per unit per shift). *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* HR Team Members will review staffing daysheets for the upcoming week during the weekly HR Meeting (agenda update) to ensure that staffing expectations are being met per above guidelines. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Daysheets with additional staffing to be turned in to DON and Administrator each week by scheduler per POC. Progress toward the successful completion of this POC will be monitored each week during HR meeting using the daysheets report. Progress toward the	

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	for help from a CNA, and 20 minutes for help from a nurse. k. A resident indicated it took 45 minutes for call lights to be answered. l. A resident indicated it took 25 minutes for call lights to be answered. m. A resident indicated there used to be two CNAs on their hall at night, but now there was only one. 2. Nurse staffing and resident need during the survey period of 1/2/19 through 1/9/19 was as follows: The administrator indicated at the beginning of the survey, there was a census of 113. A CNA sheet, dated 12/21/18, indicated the following: A/B Halls: 29 Residents, 12 with severe cognitive impairment, 8 required assist of 1 or 2, 3 up as tolerated with supervision, 1 required a lift for transfers, 8 incontinent at times, 14 incontinent, 12 required showers during day shift, 13 required showers during evening shift, and 4 that required showers during night shift. C/D Halls: 41 Residents, 10 required a lift for transfers, 9 required assist of 2 for transfers, 14 required assist of 1 for transfers, 19 incontinent, 4 with Foley catheters, 4 with colostomies, 12 required 1 assist with toileting, 7 with 2 assist with toileting, 15 required showers during day shift, 17 required showers during evening shift, and 5 that required showers during night shift. E/F Halls: 30 Residents, 11 required a lift for		successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH by comparing posted hours report with the daysheets, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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	transfers, 5 required assist of 2, 8 required assist of 1, 22 incontinent, 3 with catheters, 15 required showers during day shift, and 14 required showers during evening shift. GHI Halls: 16 Residents, 2 required a lift for transfers, 8 required assist of 2, 8 required assist of 1, 5 incontinent, 5 with Foley catheters, 2 with ostomies, 8 required showers during the day shift, 7 required showers during evening shift, and 1 required showers during night shift. On 1/4/19 at 2:07 P.M., the Dementia Disclosure was provided and indicated for 34 residents, the unit should staff: Days: 2 nurses, 2.5 CNAs Evenings: 2 nurses, 2.5 CNAs Nights: 1 nurse, 1 CNA During an interview on 1/9/19 at 12:41 P.M., the scheduler indicated the nursing schedule, based on current need, should be made to the following: Days and Evenings: A/B Halls (Dementia Unit): 2 nurses, 2 aides C/D and E/F Halls: 2 nurses, 3 aides + 1 if needed GHI Halls: 2 nurses, 2 aides Nights: A/B Halls: 1 nurse, 2 aides All other halls: 1 nurse and 1 aide per hall Staffing sheets with actual hours worked from 12/9/18 through 1/2/19 indicated the following: A/B Halls: 9 days shifts with 1 nurse/QMA, 1 of which had 1 CNA as well 7 evening shifts with 1 nurse/QMA C/D Halls:			

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	24 night shifts with 1 nurse/QMA, 12 of which had 1 CNA as well, 1 night shift with 1 aide 1 evening shift with 1 nurse E/F Halls: 6 day shifts with 1 nurse/QMA 13 evening shifts with 1 nurse/QMA 26 night shifts with 1 nurse/QMA, 17 of which had 1 CNA as well 3. Insufficient staffing was indicated by the avoidable falls by Resident E and Resident G, as well as several falls in the previous 6 months. a. On 1/4/19 at 1:32 P.M., Resident E indicated that on 1/2/19 facility staff was in a hurry to place a new mattress on her bed. Resident E indicated that instead of utilizing the full mechanical Hhoyer lift the CNA's attempted to transfer her without a mechanical lift. Resident E indicated her legs gave out and she was lowered to the ground but did hit the floor a little. Resident E indicated she had broken her knee in the fall. On 1/8/19 at 9:58 A.M., Resident E's clinical record was reviewed. The CNA assignment sheets, dated 12/31/18, indicated Resident E required a sit to stand mechanical lift for transfers. The Progress Notes included, but were not limited to: 12/24/18 at 5:00 P.M.: Resident was going to go on leave with son, assisted into wheelchair and taken out to his car. When she started to transfer into the car her right ankle popped badly and she complained of right ankle pain..... 1/2/19 at 8:37 P.M.: Earlier a little after 5:00 (name of two CNA's) attempted to manually transfer assist of two using gait belt. When lowering into chair, resident was ill postured and slid forward,			

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	CNA's attempted to ease to floor. CNA report gently easing to floor. Resident reports impact with floor and reported left hip pain after returning to bed....Resident did not want to wait for mobile x-ray and stated analgesia was insufficient and wanted to go to hospital..... 1/2/19 at 11:00 P.M.: Resident returned from (name of hospital) with immobilize to left knee and leg. Report from (name of hospital) indicated a broken knee. b. On 1/4/19 at 9:39 A.M., a loud noise was heard coming from the dining room. Someone yelled for a nurse to come to the dining room. Resident G was observed to be lying on the floor beside a wheelchair. Resident G indicated he was trying to sit on the sofa in the common area. Resident G was observed to have regular white socks on. LPN 15 returned to the nursing station and indicated Resident G was trying to self transfer from the wheelchair to the sofa and fell. LPN 15 indicated Resident G had regular socks on. On 1/4/19 at 9:45 A.M., Resident G's clinical record was reviewed. The Care Plans included, but were not limited to: Potential or falls related to difficulty walking, lack of coordination, and muscle weakness, initiated on 9/27/18. The interventions included, but were not limited to: Ensure the resident is wearing proper footwear when ambulating or mobilizing in wheelchair, initiated on 9/27/18. Do not leave in wheelchair in room, assist resident to bed or recliner, initiated on 10/29/18. c. On 1/4/19 at 10:45 A.M., a falls log was provided, and indicated the following falls from 8/2018 through 1/2019: Days: 40 falls, 10 with injury			

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	Evenings: 51 falls, 20 with injury Nights: 22 falls, 7 with injury 4. Insufficient staffing was indicated by observations of Resident J and Resident H with soiled pants and lack of incontinence care. a. On 1/7/19 at 1:10 P.M., Resident J was observed sitting in the dining area with foul odor, and a discolored stain on the back of her sweater. CNA 10 assisted Resident J to the bathroom. CNA 10 cleaned up a bowel movement from Resident J, and helped put on a new brief and set of clothes. On 1/7/19 at 1:45 P.M., Resident J's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 11/11/18, indicated cognitive status could not be assessed, resident was not on a toileting program, was frequently incontinent of urine, always incontinent of bowel, and required extensive assistance of 1 for toileting. A current care plan for bladder incontinence, dated 5/12/17, included, but was not limited to the intervention "Check the resident every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes" b. On 1/2/19 at 11:53 A.M., Resident H was observed in the common area with the back of their pants saturated. During a continuous observation on 1/8/19, the following was observed: 9:05 A.M., Resident H was sleeping in the common area in a chair. 10:44 A.M., Resident H was sleeping in the common area in a chair.			

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	10:59 A.M., CNA 10 was observed walking past Resident H to assist another resident to the bathroom. 11:15 A.M., Resident H woke up, and scooted to the edge of the chair. 11:23 A.M., Resident H got up and was directed to the dining area by LPN 9. 11:26 A.M., Resident H walked back to the common area and sat on a chair. 11:41 A.M., Resident H was directed to sit in another chair across the room by LPN 9. 11:50 A.M.. Resident H was asked if he needed to use the restroom, and declined. On 1/7/19 at 10:01 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to dementia, TBI (traumatic brain injury), and psychotic disorder. The most recent Annual MDS assessment indicated cognitive status could not be assessed, Resident H was not on a toileting program, was frequently incontinent of urine, always incontinent of bowel, and required extensive assistance of 1 for toileting. A current care plan for bladder incontinence, dated 12/13/17, included, but was not limited to the intervention "Assist resident with toileting every 2 hours and PRN" During an interview on 1/8/19 at 11:58 A.M., LPN 9 indicated Resident H was frequently incontinent, and needed to be taken to the restroom every 2 hours. On 1/8/19 at 1:49 P.M., an undated Bowel and Bladder Assessment/Retraining policy was provided. The policy indicated "...The Resident is check by caregivers on a regular basis and asked			

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	to report verbally if wet or dry ... The Resident is asked (prompted) to try to use the toilet ..." During an interview on 1/9/19 at 12:44 P.M., the DON indicated there was no specific staffing policy, and the facility followed guidelines from corporate based on census and resident need. 3.1-17(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse			

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	staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed nurse staffing sheets were posted daily for 6 of 6 days during the survey. Findings include: On 1/4/19 at 10:00 A.M., a nurse staff posting sheet was observed to be posted by the A/B hall entrance. At that time, LPN 21 indicated the same posting was at the other hall entrances as well. On 1/9/19 at 11:15 A.M., staff posting sheets were provided for the following dates: 1/2/19 1/3/19 1/4/19 1/5/19 1/6/19 1/7/19 1/8/19 1/9/19 Each staff posting sheet indicated the date and the total number of hours worked for each shift. Disciplines included RN, LPN, QMA, CNA, and NA. Specific hours were not included in the postings. During an interview on 1/9/19 at 12:44 P.M., the	F 0732	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Daily Staffing Form to be updated with the following information: Facility Name, The Current Date, total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, QMAs and Resident Census. To be posted daily, per requirement. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?*	02/08/2019

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	DON (Director of Nursing) indicated there was no policy for staff posting sheets, and that the facility followed the CMS regulations.		Daily Staffing Form to be updated with the following information: Facility Name, The Current Date, total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides and Resident Census. To be posted daily, per requirement. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Scheduler to complete Posted Nurse Staffing daily with audit in weekly HR meeting to ensure accurate information is posted daily per requirement. Manager on Duty assignments to be revised to ensure that Staffing Information is posted on Saturday/Sunday/Holiday &/or any other time Manager On Duty is assigned. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?*	

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			Progress toward the successful completion of this POC will be monitored each week during HR meeting using the *F732-20190109 Willow Manor Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH by comparing posted hours report with the daysheets, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and			

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	appetizing temperature. Based on observation, interview, and record review, the facility failed to provide appetizing and palatable meals for 2 of 9 hall trays sampled. Residents complained of unappetizing food and meals were served to residents below the facilities required temperatures. (Hall F, Hall C, Resident 4, Resident 36, Resident 50, Resident 58, Resident 89,) Findings included: 1. During an interview on 1/4/19 at 10:16 A.M., Resident 4 indicated that she sometimes went for days without eating because the food tasted bad. Resident 4 indicated she ate in her room and that the food was frequently cold. 2. During an interview on 1/4/19 at 9:53 A.M., Resident 36 indicated that the food was sometimes cold and that the food had been really bad since the new Dietary Manager started working. 3. During an interview on 1/4/19 at 10:33 A.M., Resident 50 indicated that the food was sometimes cold. Resident 50 ate in his room. 4. During an interview on 1/3/19 at 11:04 A.M., Resident 58 indicated he always ate in his room and that his food trays were frequently cold. Resident 58 indicated that since the new Dietary Manager assumed her position the food was not good. 5. During an interview on 1/4/19 at 1:22 P.M., Resident 89 indicated the food on the hall trays was not always served hot. He indicated that he had seen the food delivery cart positioned in the hall for 10 to 15 minutes before a CNA came to	F 0804	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The plate warmer in the downstairs kitchen was repaired and the steam table temps are being monitored daily. Dietary and nursing team responsible for delivering room trays to residents have been in-serviced on properly transferring items from the food carts in order to maintain temperatures within required levels. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* The plate warmer in the downstairs kitchen was repaired and the steam table temps are being monitored daily. Dietary and nursing team responsible for delivering room trays to residents have been in-serviced on properly transferring items from the food	02/08/2019

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	serve the trays, and by then the food was cold. Resident 89 indicated the kitchen staff wheeled the cart out to the halls and that the CNAs were supposed to serve the trays. He said that oftentimes CNA's would be taking residents into the dining room, feeding residents or even talking on their cell phones. 6. During an interview on 1/2/19 at 3:16 P.M., Resident 51 indicated sometimes the food was not good. 7. During an interview on 1/2/19 at 11:40 A.M., Resident E indicated the food was not good and the food was not hot upon delivery to their room 8. During an interview on 1/3/19 at 10:53 A.M., Resident 52 indicated the food was not good and the food was not hot upon delivery to their room. 9. During an observation and interview on 1/8/19 at 11:50 A.M., the food cart was wheeled out by kitchen staff and left in the hall. CNA 66 open the food cart door at 11:56 A.M., and left the food cart door open until she had served the last tray at 12:08 P.M. During an interview with CNA 66, she indicated they always left the food cart open while they were serving trays. A test tray was taken from the F hall food cart on 1/8/19 at 12:08 P.M. The following temperatures were obtained from the food tray: chicken breast was 100.7 degrees, green beans were 131.5 degrees, peas and carrots were 120.2 degrees. The chicken was dry and lacked flavor. The green beans lacked flavor. 10. During an observation on 1/8/19 at 11:44 A.M., a test tray was obtained from the C hall food cart. The following food temperatures were obtained:ham 125 degrees Fahrenheit, potatoes 133 degrees Fahrenheit, and green beans 133 degrees Fahrenheit.		carts in order to maintain temperatures within required levels. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Dietary Manager to in-service staff (Dietary, Nurses, QMAs, CNAs) regarding Food Temperatures on Service Line Policy and Procedures, and Room Service Policy and Procedure regarding Hall Trays. Food temperatures will be spot-checked coming from the food carts to ensure quality teaching moments where needed. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Dietary Manager to conduct food temperature audit to ensure that food is served at the proper temperature. Administrator or designee to conduct room service / hall trays audits to ensure Policy and Procedures are being followed to ensure that food is served at the proper temperature (including keeping the food cart doors closed	

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	During an interview on 1/9/19 at 9:31 A.M., the DM (Dietary Manager) indicated the downstairs kitchen's plate warmer was not functioning properly and did not keep plates hot enough and the staff sometimes let hall carts sit around too long before the trays were passed. On 1/8/19 at 1:50 P.M., the DON (Director of Nursing) supplied a facility policy dated 6/2018, titled, "Food Temperatures on Service Line". The policy stated, "Acceptable service temperatures are: Hot Cereal, gravy [above or equal to] 135 [degrees Fahrenheit] Casseroles [above or equal to] 135 [degrees Fahrenheit] Meat, Entrees, Eggs [above or equal to] 135 [degrees Fahrenheit] Potatoes, pasta [above or equal to] 135 [degrees Fahrenheit] Vegetables, Soup [above or equal to] 135 [degrees Fahrenheit] ..." 3.1-21(a)(2)		between delivering trays to residents). Progress toward the successful completion of this POC will be monitored using the *F804-20190109 Willow Manor Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained			

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	directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure dinnerware was cleaned and stored in a clean and sanitary environment during 2 of 2 observations for 1 of 2 kitchens observed. Water pipes were observed with an accumulation of dust, the top of the dishwasher had accumulated dust and debris, the floor was scattered with crumbs and debris, and daily cleaning schedules were not completed. (Upstairs Kitchen) Findings include: During an observation on 1/2/19 at 9:59 A.M., the dishwashing area of the upper kitchen had a build up of dust on water pipes, crumbs and debris on top of the dishwasher, and crumbs and debris across the floor. During an observation on 1/8/19 at 11:15 A.M., the dishwashing area of the upper kitchen had a build up of dust on water pipes, crumbs and debris on top of the dishwasher, and crumbs and debris across the floor.	F 0812	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The upper kitchen has been reconfigured to ensure a sanitary environment for the cleaning and storing of dinnerware. Daily cleaning schedules have been modified and the cleaning of overhead water pipes, the top of the dishwasher and the floors are included on the regular schedule conducted between the Dietary and Maintenance departments. *How will other residents having*	02/08/2019

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	During an interview on 1/9/19 at 9:31 A.M., the DM (Dietary Manager) indicated noticing things needed cleaned and that the upper kitchen was a work in progress. During review of the kitchen cleaning schedule on 1/9/19 at 1:20 P.M., daily cleaning tasks were reviewed from 12/31/18 to 1/6/19. Daily tasks were missed 7 of 7 days and weekly cleaning tasks were not documented as completed. 3.1-21(i)(2) 3.1-21(i)(3)		*the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* The upper kitchen has been reconfigured to ensure a sanitary environment for the cleaning and storing of dinnerware. Daily cleaning schedules have been modified and the cleaning of overhead water pipes, the top of the dishwasher and the floors are included on the regular schedule conducted between the Dietary and Maintenance departments. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Dietary Manager has revised Daily / Weekly Cleaning Schedules. Dietary Manager will in-service dietary and maintenance staff regarding Cleaning Schedule Policy and Procedures. Dietary Manager and Maintenance Director have coordinated cleaning job duties between the two departments (with maintenance to clean H2O pipes in kitchens and dietary staff to clean dishwasher and floor). *How will the corrective*	

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			action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Progress toward the successful completion of this POC will be monitored using the *F812-20190109 Willow Manor Audit Tool*. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	
F 0838 SS=C Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility			

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	must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and			

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	any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on interview and record review, the facility failed to complete a Facility Assessment to assess the resources needed to care for the residents of the facility for day to day operations. Findings include: On 1/2/19 at 11:00 A.M., the DON provided the "Disaster/Emergency Management Assessment". On 1/9/19 at 1:40 P.M., the Administrator indicated they had thought they had provided the Facility Assessment via the Disaster/Emergency Management Assessment. The Administrator was unsure of an assessment for resident needs and indicated he would look for it. On 1/9/19 at 2:40 P.M., the Administrator indicated the facility would review the needs in the Quality Assurance and Performance Improvement meeting but did not have anything official for the last calendar year. On 1/9/19 at 1:29 P.M., the Administrator indicated the facility did not have a policy related to a Facility Assessment.	F 0838	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The facility is aware of the requirement to complete a “Facility-Wide Assessment.” A “Facility-Wide Assessment” document was reviewed and all management personnel were in-serviced on the requirements and expectations of said requirement. The Willow Manor QAPI Committee will review and update the “Facility-Wide Assessment” as frequently as needed, but no less frequently than annually. The next review is	02/08/2019

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	3.1-13(s)		scheduled for the February QAPI Committee meeting on February 8, 2019. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* The facility is aware of the requirement to complete a "Facility-Wide Assessment." A "Facility-Wide Assessment" document was reviewed and all management personnel were in-serviced on the requirements and expectations of said requirement. The Willow Manor QAPI Committee will review and update the "Facility-Wide Assessment" as frequently as needed, but no less frequently than annually. The next review is scheduled for the February QAPI Committee meeting on February 8, 2019. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The facility is aware of the requirement to complete a "Facility-Wide Assessment." A "Facility-Wide Assessment" document was reviewed and all management personnel were in-serviced on the requirements	

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			and expectations of said requirement. The Willow Manor QAPI Committee will review and update the “Facility-Wide Assessment” as frequently as needed, but no less frequently than annually. The next review is scheduled for the February QAPI Committee meeting on February 8, 2019. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Discussion related to the “Facility-Wide Assessment” will be added to the Willow Manor StandUp (Morning Meeting) agenda and covered during all StandUp or Morning Meetings. The task associated with the completion of the “Facility-Wide Assessment” no less frequently than annually has been added to a MASTER facility calendar to ensure it will be completed timely.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for 2 of 8 residents observed for care, 2 of 2 residents reviewed for catheter care, 1 of 1 residents reviewed for isolation precautions, 1 of 1 residents observed for eye drop administration, and 3 of 31 rooms reviewed. Handwashing was not complete, isolation precautions were not followed, bathroom call light cords were dragging the floor, and urinary catheter bags were on the floor. (Resident 47, Resident 162, Resident 109, Resident J, Room 3, Room 15, Room 22, Resident D, Resident 104) Findings include:	F 0880	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Unit Managers will in-service nursing staff and conduct audits / observe care on each unit: Foley catheter care completed, Foley catheter bags and/or tubing not on	02/08/2019

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	1. During a medication pass observation on E Hall at 8:45 A.M., QMA 2 washed her hands for 13 seconds before putting on gloves and administering eye drops to Resident 47. 2. During an observation on 1/7/19 at 10:35 A.M., Resident 162 was observed lying in bed with eyes closed. There were two uncovered receptacles with red trash bag liners, one containing trash, and the other containing soiled laundry. No signage was posted on the door informing anyone to consult nurses before entry. The clinical record for Resident 162 was reviewed on 1/7/19 at 10:40 A.M. The record indicated Resident 162's diagnoses included, but were not limited to, urinary tract infection with VRE, diabetes, and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 12/4/18, indicated Resident 162 experienced cognitive impairment. The assessment further indicated Resident 162 required the assistance of two staff for bed mobility, transfers, and toileting. A care plan for Resident 162 "...VRE in the urine..." dated 1/5/19 read as follows: "...Always follow Standard Precautions protocols...Follow approximated precautions: Airborne...Contact...Droplet..." The care plan lacked documentation what type of isolation precaution should be followed. During an interview on 1/7/19 at 10:35 A.M., LPN 20 indicated Resident 162 returned from the hospital that morning on contact isolation and that there should have been a sign placed on the door instructing visitors to see the nurse before entering the room. LPN 20 also indicated there		floor, call lights within reach and accessible and call light cords not on floor, handwashing / hand hygiene per policy and eye drop administration. Call lights being within reach, easily accessible and cords not being on the floor have been added to housekeeping and maintenance room audit sheets. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Unit Managers will in-service nursing staff and conduct audits / observe care on each unit: Foley catheter care completed, Foley catheter bags and/or tubing not on floor, isolation precaution, call lights within reach and accessible and call light cords not on floor, handwashing / hand hygiene per policy and eye drop administration. Call lights being within reach, easily accessible and cords not being on the floor have been added to housekeeping and maintenance room audit sheets. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Unit Managers will in-service	

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	should be covers for the receptacles that contained the trash and the dirty laundry in the resident's room. During an interview on 1/7/19 at 11:10 A.M., the administrator indicated the trash and laundry should be covered and there should be a sign on the door notifying visitors and staff to see the nurse before entering the room. During an interview on 1/7/19 at 11:35 A.M., House Keeper 1 indicated she did not know if there were any residents on E Hall who were on isolation precautions. HK1 indicated that no signs were posted on any resident's door. HK 1 was made aware there was a sign on Resident 162's door. HK 1 said no one had told her about the isolation precaution. During an interview on 1/7/19 at 12:15 P.M., the Director of Nursing indicated the trash and the laundry needed to be in a barrel with a lid on it and there should have been a sign posted on the door to notify visitors to check with nursing before entering the room. During an interview on 1/7/19 at 11:06 A.M., the Administrator indicated it was the policy of the facility to post a sign informing visitors and staff to see the nurse before entering a room where a resident was on contact isolation and that it was the facility's policy to cover the trash and laundry receptacles in the residents' rooms. During an interview on 1/9/19 at 1:30 A.M., the Unit Manager for E and F hall indicated Resident 162 had returned from the hospital and was readmitted on 1/5/19. An undated policy "Isolation cart..." was		nursing staff and conduct audits / observe care on each unit: Foley catheter care completed, Foley catheter bags and/or tubing not on floor, isolation precaution, call lights within reach and accessible and call light cords not on floor, handwashing / hand hygiene per policy and eye drop administration. Call lights being within reach, easily accessible and cords not being on the floor have been added to housekeeping and maintenance room audit sheets. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *F880-20190109 Willow Manor Audit Tool* through observation and audit by Unit Managers. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful	

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	provided by the Director of Nursing on 1/7/19 at 12:23 P.M., and it read as follows: "...5. Post sign bearing type of isolation on Resident's door..." 3. On 1/7/19 at 9:55 A.M., CNA 17 was observed assisting Resident 109 to the restroom. After cleaning up the resident, CNA assisted him to get dressed and did not change her gloves or perform hand hygiene. 4. On 1/7/19 at 1:10 P.M., CNA 10 was observed assisting Resident J to the restroom. After cleaning up the resident, CNA 10 washed her hands. She scrubbed with soap and water for 8 seconds, then rinsed. Total wash time was 11 seconds. During an interview on 1/8/19 at 9:48 A.M., LPN 9 indicated hands should be washed for the length of time you sing the happy birthday song twice, and to wash hands with soap and water after assisting residents to the restroom, as well as between resident to resident care. 5. On 1/4/19 at 2:03 P.M., a call light string in Room 3's bathroom was observed dragging the floor. On 1/9/19 at 10:50 A.M., a call light string in Room 3's bathroom was observed dragging the floor. 6. On 1/4/19 at 1:45 P.M., a call light string in Room 15's bathroom was observed dragging the floor. On 1/9/19 at 11:00 A.M., a call light string in Room 15's bathroom was observed dragging the floor. 7. On 1/9/19 at 1:49 P.M., a call light string in Room 22's bathroom was observed dragging the floor. On 1/9/19 at 11:05 A.M., a call light string in Room 22's bathroom was observed dragging the floor.		completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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During an interview on 1/9/19 at 10:50 A.M., LPN 21 indicated the string was not supposed to be dragging the floor. The Maintenance Supervisor indicated the call light strings in the bathroom were supposed to be draped over the grab bar as to not drag the floor.

On 1/7/19 at 2:00 P.M., an undated Handwashing Procedure policy was provided. The policy indicated "... Lather all areas of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, your palms, and around your fingernails. Continue this scrubbing action for at least ten seconds. Clean your nails by rubbing them in the palm of your other hand ... Followings are instances when handwashing MUST be done ... After handling used dressings, used sputum containers, urine, bedpans or urinals, catheters, soiled linen or assisting Resident in the bathroom ..."8. During an observation on 1/2/19 at 12:19 P.M., Resident 104's catheter bag was resting on the dining room floor during lunch.

During an observation on 1/3/19 at 1:11 P.M., Resident 104's catheter bag was resting on the dining room floor.

During an observation on 1/7/19 at 1:12 P.M., Resident 104 was sitting in a recliner in the bedroom with the catheter bag was resting on top of the resident's trash can.

During record review on 1/7/19 at 10:15 A.M., Resident 104's most recent MDS (Minimum Data Set), dated 12/15/18 (admission assessment), indicated the resident had mild cognitive impairment, required extensive assistance with transfers and toileting, and had and indwelling

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	catheter. Diagnoses included, but were not limited to; malignant neoplasm of bladder, retention of urine, gross hematuria, and chronic kidney disease. Physician orders included, but were not limited to; change Foley catheter monthly, change Foley catheter bag monthly, flush Foley catheter every night shift, and Foley catheter due to history of bladder cancer. Resident 104's care plan included, but was not limited to; chronic kidney disease and gross hematuria with interventions including; use aseptic technique and universal precautions, self care deficit with a goal stating resident ADL (Activities of Daily Living) needs will be met by staff, and indwelling catheter due to bladder cancer and urine retention with interventions including; catheter care (per policy) every shift. 9. During an observation on 1/2/19 at 12:19 P.M., Resident D's catheter bag and catheter tubing were resting on the dining room floor during lunch. During an observation on 1/3/19 at 1:08 P.M., Resident D's catheter bag was resting on the dining room floor. During an observation on 1/7/19 at 10:42 A.M., Resident D's catheter tubing was observed resting on the floor of the resident's room. During record review on 1/4/19 at 9:40 A.M., Resident D's most recent MDS, dated 12/12/18 (admission assessment), indicated the resident had mild cognitive impairment, required extensive assistance with transfers, bed mobility, and toilet			

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	use, and had an indwelling catheter. Diagnoses included but were not limited to; benign prostatic hyperplasia with lower urinary tract symptoms, chronic kidney disease, and unspecified dementia. Physician orders included, but were not limited to; catheter (flush weekly), change Foley catheter bag every night shift on the 15th of each month, change Foley catheter on the 15th of each month, and Foley catheter care every shift for infection control. Resident D's care plan included, but was not limited to; indwelling catheter with interventions including catheter care (per policy) every shift, and self care deficit with a goal stating the Resident's ADL needs will be met by staff with assistance from the Resident as tolerated. During an interview on 1/7/19 at 1:16 P.M., LPN 8 indicated catheter care included performing perineal care, emptying catheter bags, keeping catheter bags covered, and keeping catheter bags and tubing off the floor. During an interview on 1/8/19 at 9:30 A.M., LPN 19 indicated it was not the facilities practice to use trash can to support catheter bags or let the bags and tubing rest on the floor. On 1/8/19 at 9:21 A.M., the DON (Director of Nursing) supplied an undated facility policy titled, "Catheter Care, Foley". The policy stated, "Foley catheter care will promote good hygiene and reduce the potential for infection." 3.1-18(b)(1) 3.1-18(l)			

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F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to follow appropriate vaccine administration guidelines for the pneumococcal vaccine. The pneumococcal vaccine was not given for those residents with an unknown vaccine status in 4 of 5 residents reviewed for vaccines. (Resident 32, Resident 51, Resident 18, Resident 41) Findings include: On 1/9/19 at 8:30 A.M., the following 5 resident clinical records were randomly reviewed for immunization status. 1. Resident 32: A pneumonia vaccine consent, dated 7/27/18, was signed by the resident. A vaccination record indicated a pneumonia vaccine (unknown type) was given historically on 6/13/02. There was no current order for the pneumonia vaccine. 2. Resident 51: A pneumonia vaccine consent,	F 0883	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Unit Managers/DON/MDS to conduct Facility Wide Audit of resident's pneumococcal vaccine records/history in order to ensure that Antibiotic Stewardship Program policy is followed regarding administration guidelines for the pneumococcal vaccine for those residents with an unknown vaccine status. All residents will	02/08/2019

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	dated 7/27/18, was signed by the resident. A vaccination record indicated a pneumonia vaccine (unknown type) was given historically on 4/20/13. Resident 51 had a current order, dated 7/9/18, for the pneumovax vaccine. 3. Resident 18: A pneumonia vaccine consent, dated 9/6/18, was signed by the resident. A vaccination record indicated a pneumonia vaccine (unknown type) was given historically on 11/1/16. Resident 18 had a current order, dated 12/29/18, for the pneumovax vaccine. 4. Resident 41: A pneumonia vaccine consent, dated 7/27/18, was signed by the resident. A vaccination record indicated a pneumonia vaccine (unknown type) was given historically on 10/1/14. Resident 41 had a current order, dated 1/17/18, for the pneumovax vaccine. During an interview on 1/8/19 at 1:30 P.M., the DON (Director of Nursing) indicated that if a resident is admitted with an unknown pneumonia vaccine status, the facility would reach out the hospital, previous facility, PCP, or family to try and get the pneumonia vaccine information. On 1/9/19 at 1:00 P.M., a current Pneumococcal Polysaccharide Vaccine (PPSV) policy was provided, revised 12/5/16. The policy indicated "... Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination ..." 3.1-13(a)		be offered Pneumococcal Vaccine if they have an unknown vaccine status &/or they have declined previously with new Consent Forms signed. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Unit Managers/DON/MDS to conduct Facility Wide Audit of resident's pneumococcal vaccine records/history in order to ensure that Antibiotic Stewardship Program policy is followed regarding administration guidelines for the pneumococcal vaccine for those residents with an unknown vaccine status. All residents will be offered Pneumococcal Vaccine if they have an unknown vaccine status &/or they have declined previously with new Consent Forms signed. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* In-service: Antibiotic Stewardship Program regarding Pneumococcal Vaccine Policy and Guidelines (Nurses/MDS). *How will the corrective action(s) will be monitored to*	

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			ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Pneumococcal vaccine audits. Unit Managers to complete new admit / readmit chart audits and ensure that if resident signed consent to receive pneumococcal vaccine that MD order is obtained and vaccine is administered. Progress toward the successful completion of this POC will be monitored using the *F883-20190109 Willow Manor Audit Tool* through observation and audit by Unit Managers. Progress toward the successful completion of this POC will be monitored daily on NORMAL BUSINESS DAYS for ONE MONTH, then WEEKLY X4 WEEKS, then SEMI-MONTHLY X4 months for a TOTAL OF SIX (6) MONTHS ensuring compliance. Progress toward the successful completion of this POC will be reviewed each weekday in StandUp and also by the Willow Manor QAPI Committee meeting (chaired by the Administrator) each month for six (6) months total. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion.	

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F 9999 Bldg. 00	1. 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a major accident was reported to the state survey agency for 1 of 2 falls with major accidents reviewed. (Resident 212) Findings include: On 1/4/19 at 1:53 P.M., Resident 212's clinical record was reviewed. A Significant Change MDS (Minimum Data Set) assessment, dated 11/9/18, indicated Resident 212 had severe cognitive impairment, was dependent of two persons for transfers, and had two falls since the prior	F 9999	*What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The policy entitled "REPORTABLE INCIDENT POLICY AND ISDH REPORTABLE UNUSUAL OCCURRENCE POLICY" was reviewed and all management personnel were in-serviced on the requirements and expectations of said policy. It is the practice of this provider to follow this policy to the letter. The facility is aware of the requirement to file the "Alzheimer's/Dementia Special Care Unit" (State Form 48896) form annually by December 31. State Form 48896 was reviewed and all management personnel were in-serviced on the requirements and expectations of said requirement. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective*	02/08/2019

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	assessment. The Progress Notes included, but were not limited to: 10/20/18 at 9:30 P.M.: Resident returned from (name of hospital) emergency room. Stitches to forehead.... An SBAR (Situation, Backround, Appearance, and Recommendation) Communication Form, dated 10/20/18, included, but was not limited to: Situation: Large laceration to forehead on 10/20/18. Appearance: Laying on right side in dining room pool of blood under resident large laceration to forehead, small laceration noted to bridge of nose Nursing notes: Resident was asleep in wheelchair and leaned forward falling out of wheelchair and hitting head on the ground..... A Non-Pressure Skin Condition Report, dated 10/21/18, indicated Resident 212 had 8 stitches across the forehead. On 1/8/19 at 10:31 A.M., the DON indicated she was unsure if the accident was reported to the state survey agency. On 1/8/19 at 3:45 P.M., the Administrator and DON indicated the incident was not reported to the state survey agency. On 1/9/19 at 9:47 A.M., the Administrator indicated the facility followed the state rules regarding reporting major accidents. 2. 5.5-4 FORM, REQUIREMENTS OF HEALTH FACILITY Sec. 4 A health facility shall do the following with the disclosure form required under section 3 of		*action(s) will be taken?* The policy entitled "REPORTABLE INCIDENT POLICY AND ISDH REPORTABLE UNUSUAL OCCURRENCE POLICY" was reviewed and all management personnel were in-serviced on the requirements and expectations of said policy. It is the practice of this provider to follow this policy to the letter. The facility is aware of the requirement to file the "Alzheimer's/Dementia Special Care Unit" (State Form 48896) form annually by December 31. State Form 48896 was reviewed and all management personnel were in-serviced on the requirements and expectations of said requirement. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Discussion related to "REPORTABLE INCIDENT POLICY…" will be added to the Willow Manor StandUp (Morning Meeting) agenda and covered during all StandUp or Morning Meetings. The facility is aware of the requirement to file the "Alzheimer's/Dementia Special	

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	this chapter: (1) Submit the form to the division in December of each year. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a Alzheimer's/Dementia Special Care Unit disclosure was submitted to the state survey agency in December 2018. Findings include: On 1/3/19 at 9:59 A.M., the Administrator indicated the facility had a locked dementia care unit. The Administrator indicated he was unsure if the facility had submitted a dementia disclosure form. The Administrator indicated he had only been employed there for four months. On 1/3/19 at 11:16 A.M., the Administrator indicated the Regional Staff indicated the dementia unit was set up in the 1990's and they were not sure where the disclosure form would be. The Administrator indicated Regional Staff had sent him a blank form. On 1/4/19 at 10:42 A.M., the Alzheimer's/Dementia Special Care Unit was provided, dated 12/31/18.		Care Unit" (State Form 48896) form annually by December 31. State Form 48896 was reviewed and all management personnel were in-serviced on the requirements and expectations of said requirement. *How will the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* Discussion related to "REPORTABLE INCIDENT POLICY…" will be added to the Willow Manor StandUp (Morning Meeting) agenda and covered during all StandUp or Morning Meetings. The deadline for the submission of Alzheimer's/Dementia Special Care Unit" (State Form 48896) form annually by December 31 has been added to a MASTER facility calendar to ensure it will be submitted timely.	