STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	04/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	5226 E 82ND ST INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00227006 and IN00226056. Complaint IN00227006- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00226056-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F323. Survey dates: April 12, 13, 17, 18, 19, 20, 21, 22, 24, 2016 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 11 Medicaid: 59 Other: 12 Total: 82 These deficiencies reflect state findings	F 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. We respectfully request a desk review be performed in regards to this plan of correction.	

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

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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2017			
F 0156 SS=A Bldg. 00	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and			

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	procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as 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.)			

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

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	jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.			

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

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	(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage to 1 of 3 residents reviewed for liability and appeal notices. (Resident 13) Findings include: The 2/14/17 social services note for Resident 13 read, "...Res (resident) has dx (diagnosis) of undifferentiated schizophrenia. She reports experiencing both command voices and delusions. Res	F 0156	F156 1.Resident # 13 resides at the facility. The guardian has been appropriately notified of the end of Medicare services. There was not a negative impact from the guardian	05/24/2017

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	just returned from recent visit from psychiatric inpatient stay, due to psychosis, being mantic (sic) phase and unstable. Res is in facility for long-term care. Res has a guardian, (name of guardian), but lives in Florida and is not involved with care, as he reports being "court ordered guardian. However, res other son, (name of son) is very connected and involved in his mothers care, as he has been to visit with her on one occasion..." The Notice of Medicare Non-Coverage for Resident 13 was provided by the BOM (Business Office Manager) on 4/17/17 at 2:15 p.m. The notice indicated coverage for her skilled nursing services would end on 2/20/17. There was no signature of Resident 13, Resident 13's representative, or family member. There was a notation on the notice, dated 2/13/17, that read, "Resident refused to sign." An interview was conducted with the MDS (minimum data set) Coordinator on 4/17/17 at 3:18 p.m. She indicated she was new to issuing notices when she issued Resident 13's notice. She stated, "Now, I would mail a notice to the guardian." An interview was conducted with the		2. The Minimum Data Set Coordinator was in serviced on Medicare beneficiary notice of noncoverage guidelines and notification of end of services guidelines. 3.Systemic changes are the Executive Director will review the Medicare beneficiary notice of noncoverage weekly at the Medicare meeting to ensure appropriate notifications have been made. 4.The results of this review will be presented every month to the QAA Committee for any further recommendations. This will be monitored every month indefinitely.	

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	District Nurse on 4/24/17 at 10:30 a.m. She indicated the facility did not have a policy regarding Notices of Medicare Non-Coverage and followed federal guidelines for issuing notices. 3.1-4(f)(3)			
F 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or			

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	licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to report allegations of abuse and neglect in a timely manner to the State Department of Health for 2 of 3 residents reviewed for abuse and the facility also failed to thoroughly investigate an allegation of neglect for 1 of 3 residents reviewed. (Resident 56 &184) Findings include: 1a. The clinical record for Resident 56 was reviewed on 4/124/17 at 11:45 a.m. The diagnoses for Resident 56 included, but were not limited to, anxiety, diabetes mellitus, insomnia and end stage renal disease. A MDS (minimum data set) assessment, dated 3/1/17, indicated Resident 56 had a BIMS (brief interview of mental status) of 13, which was indicative of no cognitive impairment. During an interview with Resident 56, on 4/13/17 at 11:39 a.m., Resident 56 answered "yes" to the question, "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse." Resident 56 indicated during night shift 6 weeks prior, he put his call light on to be assisted with incontinence care. The call light was not answered for several hours and when an aide finally came in, the aide indicated he	F 0225	1a. Resident #56 No longer resides in the facility 1b. Resident # 184 No longer resides in the facility. 2. No other resident have been found to be affected by the alleged deficient practice 3. The staff have been in -serviced on the facilities' Policy and Procedure regarding mistreatment, neglect, abuse, and misappropriation of property including investigating injuries of unknown source, resident to resident altercation reporting, prevention and State reporting requirements upon hire, quarterly and at a minimum annually. The facility has established a new tracking system to ensure timely reporting and thorough investigation. This new system will ensure appropriate reporting requirements are met to the State agency. Audits will be conducted on residents through the Angel Care program 2-3 times a week to inquire about current treatment and any care concerns that he/she might have. Any concerns will be reported immediately to the Administrator and an investigation will ensue. 4. The DNS/designee will maintain this system and will report to the Administrator daily on compliance. Any deficient findings will be	05/24/2017

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	can wait until the morning to be cleaned up. Resident #56 indicated he told the previous Director of Nursing Services about the incident. A file was provided by the Director of Nursing Services (DNS), on 4/20/17 at 10:30 a.m. The DNS indicated the file was the investigation for the above allegation. The file contained the following: -Incident Report, which indicated, "...Incident Date: 4/13/17 Incident Time: 03:01 p.m....Brief Description of Incident Description added---4/14/17...during interviews this resident reported that before he went to the hospital on 3/18/17 a C.N.A. [certified nursing assistant] from night shift did not change him and told him that day shift could do it. Resident could not recall what aide this was..." -An email confirmation, dated 4/14/17 at 4:02 p.m. It indicated the date and time the incident was reported to the State Department of Health was at the same date and time as the email confirmation. -A document titled, "Alleged Abuse, Neglect, and Exploitation Investigation Worksheet," which indicated Resident 56 reported on "4/13/17" verbal abuse by an "X" placed in the box next to verbal abuse section. The document indicated, "...What allegedly occurred? During		reported to the Administrator immediately. This plan of correction will be on-going and will be discussed at the monthly at the QAA meeting.	

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	annual survey resident reported that some time before he went to the hospital back befor [sic] 3/18/17 a CNA yelled at him[.] When and where did the alleged incident occur? couldn't recall...what is the physical description of the perpetrator...unknown...." -A document titled Alleged Abuse, Neglect and Exploitation Investigation Worksheet, indicated "Summary Report of Findings: Resident reported that someon [sic] yelled at him before he went to hospital on 3/18 [3/18/17] Resident unable to recall who the staff person was Conclusions: Staff will be reinserviced on abuse & resident rights" The document was signed by the DNS and Administrator on 4/17/17. -Several documents with resident room numbers written on them with answers to the question "Are you receiving assistance at night?" The documents did not indicate a date or time. -Resident Interviews with questions related to staff treatment. Resident room numbers with the date 4/12/17 were the identifying information on the interviews. The file did not indicate an interview with Resident 56 or staff interviews. At 12:05 p.m., on 4/20/17, an interview was conducted with the Administrator, DNS, the Social Services Director, and			

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	RN #1. The DNS indicated she filled out the Investigative Worksheets above. The DNS indicated she must've misworded the Investigative Worksheets indicating Resident 56 alleged verbal abuse instead of neglect. The DNS indicated she talked to the resident about the care provided and staff, but did not document the conversations. She further indicated the facility did not pull the schedule or timecards to see who was working in the building around the time of the allegation. The Administrator and DNS indicated, on 4/20/17 at 4:44 p.m., the facility just called Resident 56 to get relevant information from the 4/13/17 reported allegation. At 9:45 a.m., on 4/21/17, the DNS indicated no one from the facility spoke to the resident after the allegation of neglect was reported to the administrator on 4/13/17 to get a description of the incident or staff members, until 4/20/17. The DNS and Administrator indicated the facility did not do a thorough investigation for the 4/13/17 allegation. The DNS indicated there was miscommunication during the investigation and steps were missed. On 4/21/17 at 11:12 a.m., the DNS and			

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	Administrator indicated that no one in the facility reviewed past grievances for Resident 56 to see if there was a similar allegation voiced by Resident 56. 1b. On 4/20/17 at 11:15 a.m., all grievances voiced by Resident 56 were requested from the Administrator. A Complaints/Grievances Follow-Up, dated 3/15/17, was received from the Administrator on 4/20/17 at 11:40 a.m. The document indicated, "Patient Name [name of Resident 56]...What occurred? res [Resident] reports he waited 2 hours for call light to be answered, he could hear staff outside room/in halls when CNA finally entered room she said 'They will clean you up on day shift' Res remained dirty, bed dirty/soiled 2. When and where did this event occur? resident room, unable to recall exact date but states it occurred [sic] on NOC [night] shift...List of persons who saw or have knowledge of the event: UM [Unit Manager] SS [Social Services] Summary of their Interview: res unable to identify staff or exact date. UM spoke to NOC shift team regarding isolated incident call light response time and meeting resident's needs...Is this an allegation of Abuse? Yes No..." There was no identifying information to indicate if the question was answered. The document was signed by LPN #20 on 3/20/17 and the			

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	155272	A. BUILDING 00 B. WING	04/24/2017

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	Administrator on 3/15/17. During an interview, on 4/20/17 at 12:15 p.m., the Administrator indicated he was not the acting Administrator at the time of the reported incident, but signed the document because it was indicated to him the grievance was closed. After the Administrator read the grievance form, he indicated the allegation referred to possible neglect since the resident went without care. The District Nurse indicated, at 4:44 p.m., on 4/20/17, the facility was still trying to gather information related to the above grievance. She indicated LPN #20 was the acting Unit Manager at the time of the 3/15/17 grievance and they were waiting for her to come to the facility to provide further information. The current DNS and Administrator were not part of facility staff at the time of grievance. On 4/21/17 at 9:45 a.m., the DNS indicated LPN #20 indicated to them that this grievance came from a careplan meeting and they were still trying to locate the information/file from the investigation. The DNS also indicated the facility contacted the previous administrator and she was unable to recall the grievance or the investigation of it.			

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	During an interview with LPN #20 and the Social Services Director, on 4/21/17 at 11:25 a.m., LPN #20 indicated the grievance was discovered during a careplan conference, so the document was filled out at that time. LPN #20 indicated Resident 56 was unable to recall the exact date of the allegation, a description of the staff members, or if the staff continued to care for him since it was so dark in his room. During the careplan meeting, Resident 56's spouse indicated Resident 56 called her to say he needed assistance with incontinent care and was having to wait for an extended period of time. LPN #20 indicated she did not ask Resident 56's spouse to look at her call history to pinpoint a particular date of the allegation. LPN #20 also indicated she filled out the grievance with Resident 56's spouse present but did not document her statement anywhere. No residents were interviewed. Two staff members were interviewed related to the issue but the conversations were not documented. LPN #20 indicated the grievance referenced Resident 56's incontinent needs were not being addressed timely. The Social Services Director indicated the grievance indicated a possible allegation of neglect. LPN #20 further indicated a thorough investigation was not completed related to an			

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	allegation of neglect and there was no other documentation related to the allegation/grievance in the facility. 2a. The clinical record for Resident 184 was reviewed on 4/18/17 at 9:30 p.m. The diagnosis for Resident 184 included, but was not limited to: stage 2 sacral pressure ulcer. An incident report was reviewed on 4/19/17 at 9:30 a.m., of an incident that was reported to Indiana State Department of Health on 4/17/17. It indicated, "...Actual or Identified date and time of incident..Incident Date: 4/13/17, Incident Time: 4:01 p.m., Residents Involved. name of Resident (Resident 184)..Brief Description of Incident...Description added 4/17/17... During interview with facility staff, resident's (Family Member 18) reported that she believes (Resident 184) had been abused by facility staff when turning her roughly 2 days prior to that, also she believes that the staff abused (Resident 184) on the day of interview because after incontinent care, the staff left a soiled blanket on her..." A "complaints/grievances follow up" form dated 4/13/17, was provided by the Medical Records on 4/19/17 at 11:46 p.m. It indicated Family Member 18 reported to staff " she believed a staff member had abused (Resident 184) by			

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	roughly turning (Resident 184) 2 days prior. She also believed Resident 184 had been abused today when a soiled blanket was left on (Resident 184) post incontinenes (sic) care...." An interview was conduct with the Administrator (ADM), Social Services Director (SSD), Director of Nursing Services (DNS), Administrator Intern, and RN 1 on 4/19/17 at 12:38 p.m. The Administrator Intern indicated she was the staff person that had spoken to Family Member 18 on 4/13/17, regarding Resident 184. She also stated she had written the grievance on 4/13/17. The Administrator Intern indicated Family Member 18 did report she believed Resident 184 had been abused. At that time, the DNS stated she did report the incident to Indiana State Department of Health on 4/17/17, but there was a 4 day delay. The Administrator indicated allegations of abuse are to be reported to Indiana State Department of Health immediately, in accordance with state guidelines. 2b. An interview was conducted with Family Member 18 on 4/19/17 at 11:21 a.m. She had indicated she had arrived at the facility at 2:00 a.m., one morning and had pushed the button to be let in the entrance door with the green awning.			

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	Family Member 18 reported as she was standing there waiting to be let in she had observed in front of the nurse's station, a male resident sitting in his wheelchair while 2 female staff members were "twerking" (dancing in a sexual provocative manner involving thrusting hip movements and a low, squatting stance) and pulling up their shirts showing bare skin of their midsections in front of him. The male resident was just sitting there and not making any movements. Family Member 18 stated she had reported to the DNS everything she had seen when she had arrived at the facility, and she was "disgusted". Family Member 18 indicated she had asked the DNS "if that was part of their therapy?" the DNS had responded, "dancing can be part of therapy". An interview was conducted with the Administrator(ADM), Social Services Director (SSD), Director of Nursing Services (DNS), Administrator Intern, and RN 1 on 4/19/17 at 12:38 p.m. The DNS indicated Family Member 18 had reported to her the staff was "having fun and she thought it was inappropriate". DNS indicated she responded to Family Member 18 "sometimes staff do have fun with residents". The DNS stated it sounded like the staff were playing music and dancing with a resident. She			

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	indicated Family Member 18 did not use the word twerking or report staff showing their bare skin midsections . The DNS indicated twerking and showing midsections was not appropriate. An incident report was reviewed on 4/21/17 at 11:30 a.m., of an incident that was reported to Indiana State Department of Health on 4/20/17. It indicated, "...Actual or Identified date and time of incident. Incident Date: 4/19/17..Incident Time. 5:01 p.m. Residents Involved. name of resident (Resident 184)...Brief Description of Incident...description added. 4/20/17 ...reported to ed and DNS....that during a family interview with (Family Member 18), she stated that one evening upon entering facility saw 'staff twerking' and lifting their shirts to midriff in front of a male resident in the hallway..." An interview was conducted with the ADM on 4/24/17 at 10:16 a.m. He indicated the DNS had entered the reportable. He stated the DNS in error had entered the incident time when she had reported the incident to Indiana State Department of Health instead of the time they were notified of the incident on 4/19/17. The ADM stated abuse allegations should be reported within 24 hours.			

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A policy titled, Abuse, dated 10/20/16, was received from the District Nurse on 4/19/17 at 12:23 p.m. It indicated, "...The center staff reports any alleged violations involving verbal, sexual, physical, and mental abuse...and neglect of the patient..to other officials in accordance with State regulations through established procedures...."

A policy titled, ...Detecting Abuse, Neglect, Misappropriation and Injuries of Unknown Origin, dated 9/7/16, was received from the District Nurse, on 4/19/17 at 12:23 p.m. The policy indicated, "...The center staff reports any alleged violations involving mistreatment, neglect, or abuse...immediately to: ...Other officials in accordance with State regulations through established procedures (including to the State survey and certification agency)...Per the Elder Justice Act, if the reportable event does not result in serious bodily injury, report the suspicion not later than 24 hours after forming the suspicion...follow the state's regulatory agency reporting requirements for the investigation's findings...."

A policy titled, Federal Abuse, Neglect and Exploitation Definitions was provided by the District Nurse on 4/19/17

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	at 12:23 p.m. It indicated, "...Immediately[:] Defined at "as soon as possible", [sic] but no later than 24 hours. Indiana State Department of Health, Division of Long Term Care released a policy titled, "Incident Reporting Policy" with an effective date of 7/15/15. The policy indicated, "...I. Comprehensive Care Facilities A. Federal and State Rules related to incident reporting 1. Federal Regulations....The facility must ensure that all alleged violations involving mistreatment, neglect, abuse...are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency).....III. Instructions For Reporting A. Incident Reporting and Timeframe's: 1. Comprehensive Care Facilities a. An incident identified as mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property must be reported immediately after providing care and protection for the resident(s) and determining the incident meets the reporting criteria...b. Other incidents must be reported within 24 hours after discovery of the incident.... " 3.1-28(c)			

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F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on interview and record review,	F 0226	1 .Resident #56 No longer resides in	05/24/2017

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	the facility failed to implement its' abuse policy regarding investigation, reporting, and prevention for 2 of 3 residents reviewed for abuse and 4 of 10 employees whose personnel files were reviewed for annual abuse training. (CNA 7, RN 16, LPN 20, CNA 23, and Residents 56 & 184) Findings include: 1a. The clinical record for Resident 56 was reviewed on 4/124/17 at 11:45 a.m. The diagnoses for Resident 56 included, but were not limited to, anxiety, diabetes mellitus, insomnia and end stage renal disease. A MDS (minimum data set) assessment, dated 3/1/17, indicated Resident 56 had a BIMS (brief interview of mental status) of 13, which was indicative of no cognitive impairment. During an interview with Resident 56, on 4/13/17 at 11:39 a.m., Resident 56 indicated he was abused when he was not assisted with incontinent care during night shift. Resident #56 indicated he told the previous Director of Nursing Services about the incident. A file was provided by the Director of Nursing Services (DNS), on 4/20/17 at 10:30 a.m. The DNS indicated the file was the investigation for the above		the facility Resident # 184 No longer reside in the facility. 2. No other resident have been found to be affected by this alleged deficient practice 3. The staff have been in -serviced on the facilities' Policy and Procedure regarding mistreatment, neglect, abuse, and misappropriation of property including investigating injuries of unknown source, resident to resident altercation reporting, prevention and State reporting requirements upon hire, quarterly and at a minimum annually. The facility has established a new tracking system to ensure timely reporting and thorough investigation. This new system will ensure appropriate reporting requirements are met to the State agency. Audits will be conducted on residents through the Angel Care program 2-3 times a week to inquire about current treatment and any care concerns that he/she might have. Any concerns will be reported immediately to the Administrator and an investigation will ensue. Employee files will be audited monthly by the Staff Development Coordinator/designee to ensure that abuse training has been completed on all employees upon hire and at a minimum annually.	

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	allegation. The file contained the following: -Incident Report, which indicated, "...Incident Date: 4/13/17 Incident Time: 03:01 p.m....Brief Description of Incident Description added---4/14/17...during interviews this resident reported that before he went to the hospital on 3/18/17 a C.N.A. [certified nursing assistant] from night shift did not change him and told him that day shift could do it. Resident could not recall what aide this was..." -An email confirmation, dated 4/14/17 at 4:02 p.m., that indicated the allegation was reported to the State Board of Health at the same date and time of the email confirmation. -A document titled, "Alleged Abuse, Neglect, and Exploitation Investigation Worksheet" The document indicated Resident 56 reported on "4/13/17" verbal abuse by an "X" placed in the box next to verbal abuse section. The document indicated, "...What allegedly occurred? During annual survey resident reported that some time before he went to the hospital back befor [sic] 3/18/17 a CNA yelled at him[.] When and where did the alleged incident occur? couldn't recall...what is the physical description of the perpetrator...unknown...." -A document titled Alleged Abuse,		4. The DNS/designee will maintain this system and will report to the Administrator daily on compliance. Any deficient findings will be reported to the Administrator immediately. The Staff Development Coordinator will report the findings of the employee file audit monthly to the QAA committee. This plan of correction will be on-going and will be discussed at the monthly at the QAA meeting for recommendations to sustain compliance.	

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	Neglect and Exploitation Investigation Worksheet. It indicated "Summary Report of Findings: Resident reported that someon [sic] yelled at him before he went to hospital on 3/18 [3/18/17] Resident unable to recall who the staff person was Conclusions: Staff will be reinserviced on abuse & resident rights" The document was signed by the DNS and Administrator on 4/17/17. -Several documents with resident room numbers written on them with answers to the question "Are you receiving assistance at night?" The documents did not indicate a date or time. -Resident Interviews with questions related to staff treatment. Resident room numbers with the date 4/12/17 were the identifying information on the interviews. The file did not indicate an interview with Resident 56 or staff interviews. During an interview with the Administrator, DNS, the Social Services Director, and RN #1, on 4/20/17 at 12:05 p.m., the DNS indicated she filled out the Investigative Worksheets above. The DNS indicated she must've misworded the Investigative Worksheets indicating Resident 56 alleged verbal abuse instead of neglect. The DNS indicated she talked to the resident about the care provided			

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	and staff, but did not document the conversations. She further indicated the facility did not pull the schedule or timecards to see who was working in the building around the time of the allegation. At 9:45 a.m., on 4/21/17, the DNS indicated no one from the facility spoke to the resident after the allegation of neglect was reported to the administrator on 4/13/17 to get a description of the incident or staff members, until 4/20/17. The DNS and Administrator indicated the facility did not do a thorough investigation for the 4/13/17 allegation. The DNS indicated there was miscommunication during the investigation and steps were missed. On 4/21/17 at 11:12 a.m., the DNS and Administrator indicated that no one in the facility reviewed past grievances for Resident 56 to see if there was a similar allegation voiced by Resident 56. 1b. A Complaints/Grievances Follow-Up, dated 3/15/17, was received from the Administrator on 4/20/17 at 11:40 a.m. The document indicated, "Patient Name [name of Resident 56]...What occurred? res [Resident] reports he waited 2 hours for call light to be answered, he could hear staff outside			

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	room/in halls when CNA finally entered room she said 'They will clean you up on day shift' Res remained dirty, bed dirty/soiled 2. When and where did this event occur? resident room, unable to recall exact date but states it occurred [sic] on NOC [night] shift...List of persons who saw or have knowledge of the event: UM [Unit Manager] SS [Social Services] Summary of their Interview: res unable to identify staff or exact date. UM spoke to NOC shift team regarding isolated incident call light response time and meeting resident's needs...Is this an allegation of Abuse? Yes No..." There was no identifying information to indicate if the question was answered. The document was signed by LPN #20 on 3/20/17 and the Administrator on 3/15/17. During an interview, on 4/20/17 at 12:15 p.m., the Administrator indicated he was not the acting Administrator at the time of the reported incident, but signed the document because it was indicated to him the grievance was closed. After the Administrator read the grievance form, he indicated the allegation referred to possible neglect since the resident went without care. On 4/21/17 at 9:45 a.m., the DNS indicated LPN #20, who was the unit			

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	manager at the time of the grievance, indicated to them that this grievance came from a careplan meeting and they were still trying to locate the information/file from the investigation. The DNS also indicated the facility contacted the previous administrator and she was unable to recall the grievance or the investigation of it. During an interview with LPN #20 and the Social Services Director, on 4/21/17 at 11:25 a.m., LPN #20 indicated Resident 56 was unable to recall the exact date of the allegation, a description of the staff members, or if the staff continued to care for him since it was so dark in his room. During the careplan meeting, Resident 56's spouse indicated Resident 56 called her to say he needed assistance with incontinent care and was having to wait for an extended period of time. LPN #20 indicated she did not ask Resident 56's spouse to look at her call history to pinpoint a particular date of the allegation. LPN #20 also indicated she filled out the grievance with Resident 56's spouse present but did not document her statement anywhere. No residents were interviewed. Two staff members were interviewed related to the issue but the conversations were not documented. LPN #20 indicated the grievance referenced Resident 56's incontinent			

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	needs were not being addressed timely. The Social Services Director indicated the grievance indicated a possible allegation of neglect. LPN #20 further indicated there was not a thorough investigation completed related to an allegation of neglect and there was no other documentation related to the allegation/grievance. 2a. The clinical record for Resident 184 was reviewed on 4/18/17 at 9:30 p.m. The diagnosis for Resident 184 included, but was not limited to: stage 2 sacral pressure ulcer. A "complaints/grievances follow up" form dated 4/13/17, was provided by the Medical Records on 4/19/17 at 11:46 p.m. It indicated Family Member 18 reported to staff she believed a staff member had abused Resident 184 during repositioning and incontinent are. An incident report was reviewed on 4/19/17 at 9:30 a.m., of an incident that was reported to Indiana State Department of Health on 4/17/17. It indicated, "...Actual or Identified date and time of incident..Incident Date: 4/13/17, Incident Time: 4:01 p.m., Residents Involved. name of Resident (Resident 184)..Brief Description of Incident...Description added 4/17/17... During interview with facility staff, resident's (Family Member			

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	18) reported that she believes (Resident 184) had been abused by facility staff when turning her roughly 2 days prior to that, also she believes that the staff abused (Resident 184) on the day of interview because after incontinent care.." An interview was conducted with the Administrator (ADM), Social Services Director (SSD), Director of Nursing Services (DNS), Administrator Intern, and RN 1 on 4/19/17 at 12:38 p.m. The Administrator Intern indicated she was the staff person that had spoken to Family Member 18 on 4/13/17. She stated Family Member 18 had reported to her she believed Resident 184 had been abused. The Administrator Intern stated she had written the grievance on 4/13/17. At that time, the DNS stated she did report the incident to Indiana State Department of Health on 4/17/17, but there was a 4 day delay. The ADM indicated allegations of abuse are to be reported to Indiana State Department of Health immediately, in accordance with state guidelines. 2b. An incident report was reviewed on 4/21/17 at 11:30 a.m., of an incident that was reported to Indiana State Department of Health on 4/20/17. It indicated, "...Actual or Identified date and time of			

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	incident. Incident Date: 4/19/17..Incident Time. 5:01 p.m. Residents Involved. name of resident (Resident 184)...Brief Description of Incident...description added. 4/20/17 ...reported to ED and DNS....that during a family interview with (Family Member 18), she stated that one evening upon entering facility saw 'staff twerking' and lifting their shirts to midriff in front of a male resident in the hallway..." An interview was conducted with Family Member 18 on 4/19/17 at 11:21 a.m. She had indicated during a night visit, she had witnessed staff members "twerking" (dancing in a sexual provocative manner involving thrusting hip movements and a low, squatting stance) and pulling up their shirts showing bare skin of their midsections. Family Member 18 stated she had reported to the DNS. An interview was conducted with the Administrator (ADM), Social Services Director (SSD), Director of Nursing Services (DNS), Administrator Intern, and RN 1 on 4/19/17 at 12:38 p.m. The DNS indicated Family Member 18 had reported to her the staff was "having fun", and she felt it was not appropriate. She indicated Family Member 18 did not use the word twerking or report staff showing their bare skin midsections . The DNS			

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	indicated twerking and showing midsections was not appropriate. An interview was conducted with the ADM on 4/24/17 at 10:16 a.m. He indicated the DNS had entered the reportable. He stated the DNS in error had entered the incident time when she had reported the incident to Indiana State Department of Health instead of the time they were notified of the incident on 4/19/17. The ADM stated abuse allegations should be reported within 24 hours. 3. The Employee Records for CNA 7, RN 16, LPN 20 and CNA 23 were reviewed on 4/24/17 at 2:30 p.m. The Employee Records form indicated the following staff, start dates and work status: CNA 7 - 9/17/15 - full time RN 16 - 3/27/13 - PRN (as needed) 17.50 hours CNA 23 - 8/19/09 - full time LPN 20 - 1/27/15 - full time The employee personnel files did not include current annual abuse training for the following staff members: CNA 7, RN 16, CNA 23 and LPN 20. An interview was conducted with The District Nurse on 4/24/17 at 2:43 p.m.			

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	She indicated she could not provide documented annual abuse in-services prior to expiration of previous abuse training's for CNA 7, RN 16, CNA 23 and LPN 20. A policy titled, Abuse, dated 10/20/16, was received from the District Nurse on 4/19/17 at 12:23 p.m. It indicated, "...The center staff reports any alleged violations involving verbal, sexual, physical, and mental abuse...and neglect of the patient..to other officials in accordance with State regulations through established procedures...." A policy titled, ...Detecting Abuse, Neglect, Misappropriation and Injuries of Unknown Origin, dated 9/7/16, was received from the District Nurse, on 4/19/17 at 12:23 p.m. The policy indicated, "...Specify the type of allegation that is being reported. a. Physical abuse...Neglect...4. Interview any person or persons involved who have seen the event or have knowledge of the event. a. Have a scribe available to take notes during the interview. b. Interview notes should be clear and detailed. c. Interview notes should contain the full name of the person interviewed, time, and date...Gather information to address who, what, when, where and why, such as: a. Who was involved? 1) Staff 2)			

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	Patients receiving care and services 3) Another patient 4) Family...The center staff reports any alleged violations involving mistreatment, neglect, or abuse...immediately to: ...Other officials in accordance with State regulations through established procedures (including to the State survey and certification agency)...Per the Elder Justice Act, if the reportable event does not result in serious bodily injury, report the suspicion not later than 24 hours after forming the suspicion...follow the state's regulatory agency reporting requirements for the investigation's findings...." A policy titled, Federal Abuse, Neglect and Exploitation Definitions was provided by the District Nurse on 4/19/17 at 12:23 p.m. It indicated, "...Verbal Abuse[:] The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families...Neglect[:] Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...Immediately[:] Defined at "as soon as possible", [sic] but no later than 24 hours...." A policy titled, Preventing Abuse, dated 9/7/16, was provided by the District Nurse, on 4/19/17 at 12:53 p.m. It			

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	indicated "...Train 1. During orientation and through ongoing training provide staff with information regarding a. abuse and neglect. b. Complaints/grievances. c. Related reporting requirements, including prevention, intervention, and detection; and d. Patient rights to include promotion of respect for individuals including those involving the posting of an unauthorized photograph or recording of a resident on social media..." 3.1-28(a)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. Based on observation, interview, and record review, the facility failed to address the inadequate size of a resident's wheel chair cushion for 1 of 2 residents reviewed for positioning. (Resident 10) Findings include:	F 0241	F241 1. Resident #10 no longer resides in the facility. 2. Those residents found to be affected by the alleged deficient practice have been corrected 3. A facility wide audit has been	05/24/2017

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	The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia and contractures. The 3/22/17 Quarterly MDS Assessment indicated Resident 10 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. An interview was conducted with Resident 10 on 4/12/17 at 3:13 p.m. He indicated his wheel chair cushion was too short for the chair, hurt his "bottom", and didn't go back far enough. An observation of Resident 10's wheel chair was made on 4/12/17 at 3:13 p.m. The cushion did not cover the entire seat of the wheel chair. The cushion was 3 inches high. There was approximately a dollar bill length of space from the end of the cushion to the end of the seat of the wheel chair. The 5/25/16 physician's order indicated a pressure reducing cushion to chair, if needed. An interview was conducted with Resident 10 on 4/19/17 at 4:26 p.m., while he was lying in bed. He indicated he had his current wheel chair cushion		completed to assess appropriateness of the wheelchair size. The SDC or designee will provide in-service to the nursing staff on maintaining and/or enhancing resident dignity of all staff and in the orientation of all new personnel and at a minimum annually. Nursing and therapy departments have been inserviced on how to place cushions correctly in wheelchairs and to report any concerns accordingly. The Department Directors will assess resident's personal dignity and wheelchair cushion size with their Angel care rounds daily. Concerns will be reported immediately. The Social Service Director or designee will conduct individual interviews routinely to ascertain if resident has any concerns with dignity and report any complaints to the Administrator for follow through. 4. The Administrator/designee will review concern/grievance reports to identify any trends. This plan of correction will be on-going and will be reported monthly to the QAA for any recommendations to sustained compliance.	

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	for about 4 months, and stated, "I don't know why they don't get me a cushion for my chair. It's like they're just trying to make do with what they have around. When I sit in the chair, it feels horrible. That's why I'm not in it now. I can only spend 2 to 4 hours in it. It has me all crooked, and makes my bottom hurt. It's just terribly uncomfortable. I didn't go to the movie (name of movie) today, because I can't sit in that chair that long. It's not worth suffering through. I'm almost in tears, when I go get my haircut, because of the cushion." An observation of Resident 10 in his wheel chair was made on 4/20/17 at 9:52 a.m. His buttocks was hanging off the back of the cushion, approximately the length of a dollar bill . He indicated CNA (Certified Nursing Assistant) #7 assisted him into his wheel chair that morning. An interview was conducted with CNA #7 on 4/20/17 at 10:19 a.m. She stated, "I know his (expletive) hangs off the cushion in his wheel chair. He says he's uncomfortable, and always tells me, so that's why he doesn't stay up long....I never told anyone. He said he's waiting on somebody to do something about it..." An interview was conducted with CNA			

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	#6 on 4/20/17 at 10:06 a.m. She stated, "He pulls the cushion to the front, before he gets into it. I don't know why. I noticed his cushion doesn't go all the way to the back and cover the whole seat....I haven't told anyone about the wheel chair cushion." An observation of Resident 10's wheel chair was made with the Therapy Director, Occupational Therapist #9, and Resident 10 on 4/20/17 at 10:27 a.m. OT #9 stated, "His cushion is supposed to be facing the other way. (OT #9 turned the cushion 45 degrees clockwise.) We talked about this back in January and this was the solution. We have tried other cushions in house, not sure if we've looked into ordering a new one." Resident 10 stated, "It's painful. My (expletive) hangs off. If you turn it sideways, my legs hang off." An interview was conducted with the Therapy Director on 4/20/17 at 10:41 a.m. He stated, "We can look into getting a new one. I think the cushion would be okay, if turned the other way with some dycem. This is his personal wheel chair, and we can only do so much. We addressed it 3 times. If nursing would mention it, we'd have addressed it. Regular cushions, we take care of. His would be special. He had a different			

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	cushion before. We ordered a new one at the time he discharged from OT on 1/5/17. I'm unsure, if the one in the chair now, is the one we ordered. He hadn't mentioned it the last time he was on caseload....We'll get a deeper cushion for the wheel chair." An observation of Resident 10 in his wheel chair, actively participating in therapy, was made on 4/20/17 at 11:08 a.m. His buttocks was hanging off the back of his wheel chair cushion. Nine inches of buttock crack was easily observed, when looking at the back of the wheel chair. The back of the wheel chair was facing the therapy room exit door, and was easily observable, when walking down the hall, past the therapy room. The above observation was also made with RN (Registered Nurse) #1 on 4/20/17 at 11:11 a.m. She stated, "That is inappropriate." The Patient Rights policy was provided by RN #1 on 4/20/17 at 12:35 p.m. It read, "Staff of the facility is expected to protect and promote each patient's rights, including the right to a dignified existence..." 3.1-3(t)			

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F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			

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	Based on interview and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessments regarding oral/dental status and a resident's use of a wheelchair for 2 of 14 residents reviewed for MDS accuracy (Residents 127 & 10) Findings include: 1. The clinical record for Resident 127 was reviewed on 4/18/17 at 11:45 a.m. The diagnoses for Resident 127 included, but were not limited to, diabetic mellitus, aortic vale replacement, and dementia. During an interview with Family Member #2, on 4/17/17 at 9:39 a.m., Family Member #2 indicated Resident 127 has "bad teeth." During an observation, on 4/18/17 at 12:20 p.m., Resident 127 was observed with several discolored, broken teeth on the bottom. An Admission MDS (minimum data set) assessment, dated 11/8/16, did not indicate any dental concerns. During an interview with CNA #3 and LPN #4, on 4/19/17 at 2:34 p.m., they indicated Resident 127's bottom teeth had been broken and discolored since his	F 0278	F278 1a. The MDS for Resident # 127 has been corrected. A corrected MDS has been transmitted. 1b. Resident # 10 no longer resides in the building 2. Those residents found to be affected by the alleged deficient practice have been corrected. 3. The Interdisciplinary Team will review the most current oral assessment and wheelchair usage and then compare outcomes to MDS for each resident to assess for accuracy and correct any information determined to be inaccurate The District Director of Case Management will in service the Interdisciplinary Team on the accuracy of the information coded on each MDS. The Interdisciplinary Team members will verify the accuracy of the coded information on each MDS prior to affixing their signatures. The District Director of Case Management or designee will monitor through observation and record review the accuracy of the MDS. The date will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with a subsequent plan of action developed and implemented as indicated.	05/24/2017

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	admission to the facility. On 4/21/17 at 12:05 p.m., the MDS Coordinator indicated the dental status for the 11/8/16 Admission MDS was not accurately documented. 2. The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia. The 6/17/16 Occupational Therapy-Therapist Progress & Discharge Summary read, "Skilled interventions included wheelchair positioning...Patient educated on wheelchair seating and positioning..." The 3/22/17 Quarterly MDS (minimum data set) assessment indicated Resident 10 did not use a wheel chair as a mobility device. An observation of Resident 10's wheel chair, in his room, was made on 4/12/17 at 3:13 p.m., with Resident 10. He referenced concerns regarding his wheel chair. An observation of Resident 10 was made on 4/17/17 at 2:10 p.m. He was in his wheel chair, in the hallway. An observation of Resident 10 in his		4. The results of the audits will be presented to the monthly QAA until substantial compliance is determined The Administrator is responsible for the overall compliance.	

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	wheel chair, actively participating in therapy, was made on 4/20/17 at 11:08 a.m. An observation of Resident 10 in his wheel chair was made with RN (Registered Nurse) #1 on 4/20/17 at 11:11 a.m. An interview was conducted with the District Nurse (DN) on 4/20/17 at 4:22 p.m. She stated, "The MDS is incorrect. He has a wheel chair." 3.1-31(d)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.			

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	483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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.			

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	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to develop care plans related to delusions or hallucinations and contractures for 2 of 14 residents reviewed for care plans (Resident 56 & 10) Findings include: 1. The clinical record for Resident 56 was reviewed on 4/124/17 at 11:45 a.m. The diagnoses for Resident 56 included, but were not limited to, anxiety, diabetes mellitus, insomnia and end stage renal disease. A Progress Note, dated 3/31/17 at 11:32 p.m., indicated, "Res [Resident] A/O [alert/oriented] x3 with intermittent confusion and hallucinations..." A Progress Note, dated 4/1/17 at 2:58 a.m., indicated, "A&O with some confusion. Hallucinations at times...	F 0279	1a Resident # 56 no longer resides in the facility 1b. Resident #10 no longer resides in the facility 2. Interdisciplinary Care Planning Team will review resident care plans and develop a schedule to complete comprehensive care plans on residents identified through the process. . Those residents found to be affected by the alleged deficient practice have been corrected. 3) The District Director of Case Management will conduct an in-service for the Interdisciplinary Care Planning Team on development of a comprehensive care plan. The Interdisciplinary Care Planning Team will develop a comprehensive care plan on at least a quarterly basis to address areas identified through the RAI process. The District Director of Case Management, or her designee, will monitor through resident record review (care plans), monthly for three months, then at least	05/24/2017

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	A Late Entry Progress Note, dated 4/2/17 at 4:11 a.m., "pt [patient] has night confusion as usual...pt told nurse 'they are filming infomercial's in my house and I did not give them permission.'...pt as usual has delusions at night, more prone to confusion at night and more difficult to reorient...." A Physician's Progress Note, dated 4/4/17, indicated, "...male...with hx [history] intermittant [sic] hallucinations...." During an interview with the Administrator, on 4/24/17 at 10:22 a.m., the Administrator indicated he was told by nursing staff that Resident 56 had delusions at night time. A Delusions/Hallucinations Care Plan was not located in the clinical record. During an interview with RN #1, on 4/24/17 at 10:22 a.m., RN #1 indicated she did not see a care plan related to hallucinations/delusions at that time, but the facility will continue to review the clinical record. At 1:43 p.m., on 4/24/17, the District Nurse indicated the facility was not able to locate a delusions/hallucinations care		quarterly, to assure each resident has a comprehensive care plan. 4) The results of the audits will be presented to the monthly QAA until substantial compliance is determined. The Administrator is responsible for overall compliance.	

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	plan and Resident #56 should have one. 2. The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia and contractures. An interview was conducted with the ADNS (Assistant Director of Nursing Services) on 4/13/17 at 9:17 a.m. He indicated Resident 10 had a contracture to his right hand, but did not receive range of motion services or have a splint device in place. He stated, "He does not have a splint." The 4/12/17 Occupational Therapy (OT) Therapist Progress & Discharge Summary indicated, "Splinting: Time...The patient will tolerate right wrist extension for 6 -8 hours 4/7 nights/week with application of functional position splint in order to prevent deformity. Start of Goal Status as of 3/22/17...The patient tolerates right functional position splint for 4 hours. Prior Level as of 4/5/17...The patient tolerates right hand splint for 4 hours when donned. Pt (patient) reports nursing does not don at night and he has had increased pain. End of Goal Status as of 4/12/17...The patient tolerates right hand splint for 6 hours when donned. Pt reports nursing does not don at night and			

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	he has had increased pain....Pt has R WHFO (splint) and is able to wear it for 6 hours with no discomfort. Pt requires staff assistance to don splint and is able to remove it mod I with occasional difficulty manipulating straps. OT has discussed and made environmental adaptations in room so pt is better able to reach his personal items....Staff aware of Pt's need for splint application. Pt is able to request this on his own at the time he would like....Pt has met most goals. He can request splint application in the evenings and is able to remove it mod I....DC (discharge) to LTC (long term care). Pt to wear R (right) splint 6-8 hours in the evening or at night." An observation of Resident 10 was made on 4/12/17 at 3:20 p.m. He had a contracture to his right hand. The 3/22/17 Quarterly MDS Assessment indicated Resident 10 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. An interview was conducted with Resident 10 on 4/12/17 at 3:20 p.m. He indicated he had a splint for his right hand, wore it the previous night, and should wear it daily. An observation of Resident 10 was made			

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	on 4/17/17 at 2:10 p.m. He was in his wheel chair, in the hallway. He was wearing a splint on his right hand. An interview was conducted with CNA (Certified Nursing Assistant) #6 on 4/20/17 at 10:06 a.m. She stated, "Sometimes he wears a splint..." An interview was conducted with OT (Occupational Therapist) #9 on 4/20/17 at 10:27 a.m. She stated, "He has a splint. I wrote orders. He's supposed to be wearing it all night." An interview was conducted with Resident 10 on 4/20/17 at 3:40 p.m. He stated, "I've had the splint for a few weeks or more. (Name of therapist), another OT, helped me get the splint. I was told I could use it, as I could stand it. I am supposed to take it off from time to time. I didn't have a schedule or anything....No aides or nurse have ever offered to put it on me. The times I have used it, it was therapy that put it on. It would be helpful for staff to offer to put it on me. I'd be fine with it. It can't benefit me, if I'm not using it." An interview was conducted with CNA #12 on 4/20/17 at 3:46 p.m. She stated, "One of the therapists showed me a few weeks ago how to put it on, but I don't			

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	really feel comfortable, because I'm not really sure how to do it, and I don't want to mess up his arm." Resident 10's care plans were reviewed. There was no care plan regarding contractures or the use of a splint. An interview was conducted with the DNS on 4/20/17 at 3:54 p.m. She stated, "Typically he should have a care plan regarding his contractures. Splint use should be an intervention on the contracture care plan. 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow the plan of care for administration of pain	F 0282	1a.Resident #125 Protective boots had been added to MAR and C.N.A assignment sheet	05/24/2017

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	medication, insulin administration, lab orders, lab refusals and application of heel lift boots for 3 of 26 residents reviewed for plan of care. (Residents 127, 10, 125) Findings include: 1a. The clinical record for Resident 127 was reviewed on 4/18/17 at 11:45 a.m. The diagnoses for Resident 127 included, but were not limited to, diabetic mellitus, aortic vale replacement, and dementia. A Physician's Order, dated 2/21/17, indicated to give 14 units of Novolog (insulin) at mealtimes. A Physician's Order, dated 2/21/17, indicated to hold mealtime 14 units of Novolog for blood glucose readings less than 110. The March 2017 MAR (medication administration record) indicated by a checkmark that 14 units of Novolog were administered when the following blood glucose readings were obtained: 3/2/17 at 6:00 am.=72 3/4/17 at 6;00 a.m.=88 3/5/17 at 6:00 a.m.=82 3/16/17 at 6:00 a.m.=92 3/21/17 at 4:00 p.m.=72 3/23/17 at 4;00 p.m.=74		1b. Resident #127 Insulin orders have been readjusted, Lab times for this resident have been adjusted for compliance and resident has not refused labs. TSH has been completed. 1c. Resident #10 no longer resides in facility 2. All residents have been audited. Those residents found to be affected by the alleged deficient practice have been corrected. 3. Daily audits have been initiated to ensure the implementation of medication administration of medication follow-through, daily lab refusals, lab completion as ordered , additionally a review of the MD& NP progress notes to ensure all recommendations are followed. Licensed Nurses have been in serviced on accuracy of medication administration, evaluating reasons and alternative for lab refusals, notification of MD of refusals, and importance of lab completion. A random audit will be completed on the above three times per week by the Unit managers/designee to ensure compliance. The results will be reviewed at the next day IDT meeting for any needed education 4. The DNS is responsible for ensuring compliance with this standard. The results of the audit	

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	3/25/17 at 11:00 a.m.=84 3/26/17 at 6:00 a.m.=84 3/27/17 at 6:00 a.m.=92 3/27/17 at 11:00 a.m.=101 3/28/17 at 11:00 a.m.=101 3/29/17 at 6:00 a.m.=87. The April 2017 MAR (medication administration record) indicated by a checkmark that 14 units of Novolog were administered when the following blood glucose readings were obtained: 4/6/17 at 6:00 a.m.=73 4/8/17 at 6:00 a.m.=79 4/9/17 at 6:00 a.m.=90. 1b. A Physician's Order for Resident 127, dated 2/21/17, indicated if blood glucose readings were 350-450, give 8 units Novolog (insulin) in addition to mealtime/14 units of Novolog . The March 2017 MAR (medication administration record) indicated with a checkmark that 8 units of Novolog was administered, in addition to the mealtime/14 units of Novolog, 3/1/17 through 3/9/17 and 3/18/17 through 3/31/17 at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. The MAR indicated the blood glucose readings were under 350 on the above dates and times. The March 2017 MAR also indicated the		will be discussed at the QAA meeting on a monthly basis until full compliance has been achieved.	

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	following blood glucose readings and indicated with a checkmark that 8 additional units of Novolog was given at mealtimes with the 14 units of Novolog: 3/11/17 at 11:00 a.m.=450 3/13/17 at 9:00 p.m.=433 3/14/17 at 11:00 a.m.=387. The April 2017 MAR indicated with a checkmark that 8 units of Novolog was administered 4/1/17 through 4/18/17 at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. with the exception of the following dates, which were blank or there was no blood glucose reading on the MAR: 4/4/17 at 6:00 a.m. 4/7/17 at 11:00 a.m. 4/12/17 at 6:00 a.m. 4/17/17. at 6:00 a.m. If a blood glucose reading was obtained 4/1/17-4/18/17, the reading was below 350. The April 2017 MAR also indicated the following blood glucose readings and indicated with a checkmark that 8 additional units of Novolog was given at mealtimes with the 14 units of Novolog: 4/12/17 at 11:00 a.m.=370 4/13/17 at 4:00 p.m.=388 4/16/17 at 6:00 a.m.=393 4/16/17 at 11:00 a.m.=360 4/18/17 at 6:00 a.m.=378.			

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During an interview with RN #1, on 4/21/17 at 12:14 p.m., RN #1 indicated the facility was unable to determine if the Physician's Orders for the insulin to be held was done as ordered on the above dates or if additional 8 units of Novolog was administered/not administered as ordered for the dates above.

1c. A Nurse Practitioner Visit Note by Nurse Practitioner #30, dated 3/6/17, indicated, "...Chief Complaint...Type 2 diabetes mellitus...Accuchecks QID [4 times a day]. He [Resident 127] is on a controlled Carb diet. I will order a CBC [routine lab], BMP [routine lab], TSH x1 [thyroid lab]...."

A Physician's Order, dated 3/6/17, for a CBC, BMP, and HgbA1C [lab for blood glucose monitoring] was located in the clinical record.

The lab results for the CBC, BMP, and HgbA1C was located in the clinical record.

The TSH lab results was not located in the clinical record.

During an interview with Nurse Practitioner (NP) #30, on 4/21/17 at 3:30 p.m., NP #30 indicated she was unsure if

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	she or the facility wrote the above order for labs, but she would like the TSH lab to be drawn as indicated in her 3/6/17 note, since his last lab for TSH was borderline. 1d. The April 2017 Physician's Orders indicated an lab order for PT/INR (lab to monitor blood clotting) every Tuesday and Friday. The order was initiated on 12/19/16. The Results of Pro-time/INR indicated resident refusals of the lab on the following dates and times: 2/21/17 at 2:45 a.m., 3/7/17 at 12:00 a.m., 4/4/17 at 3:45 a.m., 4/11/17 at 12:00 a.m., 4/14/17 at 12:00 a.m., 4/18/17 at 12:00 a.m. A care plan with the focus of, "...is resistive to care r/t [related to] behaviors:...blood draws" and had interventions of allowing the resident to "...make decisions about treatment regime" and educating "...caregivers of possible outcomes of not complying with treatment or care." The care plan was initiated on 11/9/16 and remained current at the time of review. During an interview with the Director of			

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	Nursing Services, on 4/18/17 at 1:56 p.m., she indicated the facility will discuss with the Physician or Nurse Practitioner about Resident 127's refusals of PT/INR labs, since the facility was unable to locate an indication that it was previously addressed with the Physician or Nurse Practitioner. On 4/19/17 at 2:36 p.m. Physician #31 indicated she did not recall discussing Resident 127's refusals of PT/INR labs and it needed to be determined why he is refusing his labs. A Physician Progress Note by Physician #31, dated 4/19/17, indicated, "...subtherapeutic international normalized ratio (INR)...restart coumadin [blood thinner] at 3 mg [milligrams] 1 po [by mouth] daily and contine [sic] INR's [sic] twice weekly. Discuss situation with Nursing staff, Will ask lab to only draw on 2nd or 3rd at 10 am or later t [to] see if this improves his compliance...." During an interview with NP #30, on 4/21/17 at 3:30 p.m., she indicated she doesn't recall the facility discussing Resident 127's refusals of PT/INRs with her and she agrees with Physician #31's plan. At 11:14 a.m., on 4/24/17, the Director of			

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	Nursing Services indicated, staff indicated that Resident 127 didn't like early morning lab draws. 2. The clinical record for Resident 10 was reviewed on 4/24/17 at 9:45 a.m. The diagnoses for Resident 10 included, but were not limited to, chronic pain, paraplegia, history of traumatic fracture. During an interview with Resident 10, on 4/22/17 at 2:30 a.m., Resident 10 indicated he asked a CNA [certified nursing assistant] at 11:00 p.m. (4/21/17) to tell his nurse that he needed a pain pill. Resident 10 further indicated when his pain pill was administered at 4:00 p.m. on 4/21/17, the nurse told him it was his last pain pill unless a delivery was made that night (4/21/17) because the facility forgot to order the medication. QMA #28 came into Resident 10's room and asked if he needed anything. Resident 10 indicated he would like a pain pill and QMA #28 indicated she was wondering why he had not asked for one earlier. During an interview with QMA #28, on 4/22/17 at 2:35 a.m., QMA #28 indicated she administers Resident 10's medication but he was the only Resident that she administered medication to on that hallway. QMA #28 indicated LPN #29 said something about pain medication			

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	during report for Resident 10, but did not specify what was reported. QMA #28 indicated Resident 10 had an order for oxycodone (narcotic pain reliever) as needed every 6 hours and the Resident had to ask for the medication. On 4/22/17 at 2:45 a.m., LPN #29 indicated Resident 10 no longer had any oxycodone available for administration so she will pull Tylenol from the emergency drug kit and if Resident 10 preferred to have oxycodone, the facility will need to call to get preauthorization to pull it from the emergency drug kit. At 2:47 a.m., on 4/22/17, LPN #29 provided Tylenol to Resident 10 and he indicated he would prefer oxycodone and gave LPN #29 the Tylenol back. The April 2017 Physician's Orders indicated an order for Oxycodone HCL 30 milligrams to be given as needed every 6 hours. The April 2017 MAR (medication administration record) indicated Oxycodone 30 milligrams was effective at 4:20 p.m. on 4/21/17. The MAR did not indicate Oxycodone was administered until 4/23/17 at 12:07 a.m. The Controlled Substance Record			

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	indicated Oxycodone was administered on 4/21/17 at 4:24 p.m. and next Oxycodone was administered on 4/22/17 at 5:35 a.m. During an interview with the District Nurse and RN #1, on 4/24/17 at 10:17 a.m., they indicated an alert pops up on the electronic medical record when medication was running low and the staff member just needs to click the confirmation to reorder the medication at that time. RN #1 indicated at 1:58 p.m., that Resident 10 did not receive Oxycodone until 4/22/17 at 5:35 a.m., as the clinical record indicated. 3. The clinical record for Resident 125 was reviewed on 4/13/17 at 9:10 a.m. The diagnoses for Resident 125 included, but were not limited to: hemiplegia, hemiparesis, and pain. An interview was conducted with the ADNS (Assistant Director of Nursing) on 4/13/17 at 9:20 a.m. He indicated Resident 125 had an unstageable pressure ulcer to her left outer ankle. The 4/15/17 Weekly Pressure Ulcer Report indicated she had an unstageable pressure ulcer to her left outer ankle that			

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	measured 0.4 x 0.4 x 0.1 c. It was round/ oval shaped, and initially observed on 3/18/17. The report read, "history of pressure injury to this area, preferred side lying position with knees together, pillows and boots use for positioning and offloading as resident allows, area, shows improvement, wound healing impacted by hemiplegia, hyperlipidemia, pain." The April, 2016 Physician's Orders read, "heel lift boots every shift for prevention," with a start date of 3/18/17. The 4/14/17 pressure ulcer care plan indicated an intervention, initiated 3/18/17, was to encourage her to wear heels up boots. An observation was made on 4/21/17 at 9:45 a.m. RN #10 changed Resident 125's dressing to her left outer ankle. The wound was the size of a quarter. After applying the dressing, RN #10 did not apply Resident 125's heel boots. An interview was conducted with RN #10 on 4/21/17 at 9:50 a.m. She stated, "She admitted to us with a wound to the same area, and it resolved, then opened back up. She has the same boots and air mattress she's always had." An observation was made on 4/21/17 at			

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	11:04 a.m. She was lying in bed on her right side. She was not wearing heel boots. An interview was conducted with the ADNS on 4/24/17 at 9:21 a.m. He indicated Resident 125 was supposed to have heel boots on every shift, and the CNA's (Certified Nurse Aides) were responsible for ensuring her boots were on. An observation was made with the ADNS, of Resident 125 lying in bed on her left side, on 4/24/17 at 9:22 a.m. She was not wearing heel boots. An observation was made with CNA #3 on 4/24/17 at 9:23 a.m. CNA #3 retrieved heel boots from the closet and applied them to her feet. CNA #3 stated, "Normally the boots are on. She'll keep the one on her sore foot, and kick the other off." Resident 125 was asked if she was okay with having the boots on, and she nodded her head. The Prevention and Treatment of Pressure Ulcers and Other Skin Alterations policy was provided by the District Nurse on 4/24/17 at 10:54 a.m. It read, "The facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin			

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	alterations, promote healing of existing wounds and prevent further development of additional skin alterations....The Interdisciplinary team and patient/family collaborates to establish goals and interventions to promote the healing of wounds and/or prevent further breakdown." 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to address the inadequate size of a resident's wheel chair cushion for 1 of 2 residents reviewed for positioning. (Resident 10) The facility also failed to address a resident's bowel movement status for 1 of 1 residents reviewed for hospitalization. (Resident K) Findings include: 1. The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia and contractures. The 3/22/17 Quarterly MDS Assessment indicated Resident 10 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. An interview was conducted with Resident 10 on 4/12/17 at 3:13 p.m. He indicated his wheel chair cushion was too short for the chair, hurt his "bottom", and	F 0309	1a. Resident # 10 no longer resides in the facility 1b. Resident K. Unable to determine name of resident as was a complaint survey. 2. All residents have been audited. Those residents found to be affected by the alleged deficient have been corrected. 3. The licensed nurses will be in serviced on how to monitor the clinical dashboard in the electronic medical record for the alert when a resident has not had a bowel movement in an appropriate timeframe and the next necessary actions. The IDT will also monitor the clinical dashboard for these alerts in the clinical morning meeting, M-F and address any concerns as needed. The wheelchair cushion size will be observed on Angel Rounds. Any concerns will be communication to therapy for evaluation. 4. This POC will be on-going will be discussed monthly at the QAA meeting to identify and trends and	05/24/2017

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	didn't go back far enough. An observation of Resident 10's wheel chair was made on 4/12/17 at 3:13 p.m. The cushion did not cover the entire seat of the wheel chair. The cushion was 3 inches high. There was approximately a dollar bill length of space from the end of the cushion to the end of the seat of the wheel chair. The 5/25/16 physician's order indicated a pressure reducing cushion to chair, if needed. An interview was conducted with Resident 10 on 4/19/17 at 4:26 p.m., while he was lying in bed. He indicated he had his current wheel chair cushion for about 4 months, and stated, "I don't know why they don't get me a cushion for my chair. It's like they're just trying to make do with what they have around. When I sit in the chair, it feels horrible. That's why I'm not in it now. I can only spend 2 to 4 hours in it. It has me all crooked, and makes my bottom hurt. It's just terribly uncomfortable. I didn't go to the movie (name of movie) today, because I can't sit in that chair that long. It's not worth suffering through. I'm almost in tears, when I go get my haircut, because of the cushion."		need for the further education.	

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	An observation of Resident 10 in his wheel chair was made on 4/20/17 at 9:52 a.m. His buttocks was hanging off the back of the cushion, approximately the length of a dollar bill. He indicated CNA (Certified Nursing Assistant) #7 assisted him into his wheel chair that morning. An interview was conducted with CNA #7 on 4/20/17 at 10:19 a.m. She stated, "I know his (expletive) hangs off the cushion in his wheel chair. He says he's uncomfortable, and always tells me, so that's why he doesn't stay up long....I never told anyone. He said he's waiting on somebody to do something about it..." An interview was conducted with CNA #6 on 4/20/17 at 10:06 a.m. She stated, "He pulls the cushion to the front, before he gets into it. I don't know why. I noticed his cushion doesn't go all the way to the back and cover the whole seat....I haven't told anyone about the wheel chair cushion." An observation of Resident 10's wheel chair was made with the Therapy Director, Occupational Therapist #9, and Resident 10 on 4/20/17 at 10:27 a.m. OT #9 stated, "His cushion is supposed to be facing the other way. (OT #9 turned the cushion 45 degrees clockwise.) We talked about this back in January and this			

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	was the solution. We have tried other cushions in house, not sure if we've looked into ordering a new one." Resident 10 stated, "It's painful. My (expletive) hangs off. If you turn it sideways, my legs hang off." An interview was conducted with the Therapy Director on 4/20/17 at 10:41 a.m. He stated, "We can look into getting a new one. I think the cushion would be okay, if turned the other way with some dycem. This is his personal wheel chair, and we can only do so much. We addressed it 3 times. If nursing would mention it, we'd have addressed it. Regular cushions, we take care of. His would be special. He had a different cushion before. We ordered a new one at the time he discharged from OT on 1/5/17. I'm unsure, if the one in the chair now, is the one we ordered. He hadn't mentioned it the last time he was on caseload....We'll get a deeper cushion for the wheel chair." The Positioning the Resident policy was provided by RN #1 on 4/20/17 at 11:40 a.m. It read, "Position the resident for proper body alignment....Report any complaints of pain to the charge nurse." 2. The clinical record for Resident K was reviewed on 4/19/17 at 1:45 p.m. The			

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	diagnoses for Resident K included, but were not limited to, schizophrenia, anxiety, and anemia. A MDS (minimum data set) assessment, dated 12/2/16, indicated Resident K needed extensive assistance with 2+ people for transfers and extensive assistance with 2+ people for toilet use. The MDS assessment also indicated Resident K was always incontinent of bowel. The Bowel Continence/Movements record indicated the following: 1/13/17 at 10:23 p.m.-Incontinent, 1/14/17 at 10:12 p.m.-No Bowel Movement, 1/16/17 at 10:46 p.m.-No Bowel Movement, 1/17/17 at 9:32 p.m..-No Bowel Movement, 1/18/17 at 3:35 a.m.-No Bowel Movement, 1/18/17 a 2:59 p.m.-No Bowel Movement, 1/18/17 at 10:01 p.m.-No Bowel Movement, 1/19/17 at 4:45 p.m.-No Bowel Movement, 1/20/17 at 10:35 p.m.-No Bowel Movement, 1/21/17 at 4:51 a.m.-No Bowel Movement,			

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	1/22/17 at 7:16 p.m.-No Bowel Movement, 1/23/17 at 10:23 a.m..-No Bowel Movement, 1/23/17 at 7:55 p.m.-No Bowel Movement 1/24/17 at 2:48 p.m.-Continent 1/24/17 at 10:31 p.m.-Incontinent. There was no other indication in the clinical record that Resident K had a bowel movement (BM) before 1/24/17 at 10:31 p.m. . During an interview with the Assistant Director of Nursing (ADON), on 4/24/17 at 1:24 p.m., the ADON indicated he was familiar with Resident K, but could not recall if the facility addressed Resident K's bowel movement status during the above days. The January 2017 Physician's Orders indicated an order for milk of magnesia 30 milliliters to be given twice daily as needed for constipation. The order was started on 5/19/15. The January 2017 MAR (medication administration record) did not indicate milk of magnesia was administered to Resident K during the month of January. Resident K did not have a care plan for			

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	constipation or a diagnosis of constipation. During an interview with the District Nurse, on 4/24/17 at 12:30 p.m., the District Nurse indicated there was an alert that popped up in the electronic medical record indicating a resident had not had a BM in 3 days. When the alert pops up, staff was supposed to look at the resident's orders for PRN (as needed) medications for constipation and administer the medication as ordered. If there was no BM after the medication was administered, the facility should notify the physician. Physician notification related to the bowel movement status for Resident K was not located in the clinical record. The District Nurse indicated, at 2:41 p.m.,on 4/24/17, the facility was unable to determine if Resident K had a BM during the between the dates 1/14/17 and 1/23/17, if medication was provided for constipation, or if the physician was notified of the bowel movement status. She also indicated Resident K did not have a care plan for constipation. A policy titled, Bowel Elimination , dated 8/31/12, was provided by the District Nurse on 4/24/17 at 12:00 p.m. The			

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	policy indicated "...29. If no bowel movement according to patient's established pattern, follow physician's orders or notify physician...assess for cause and notify physician to discuss interventions, obtain physician's orders...." This Federal Tag relates to Complaint #IN00226056. 3.1-37(a)			
F 0313 SS=D Bldg. 00	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to follow up with an	F 0313	1.Resident #169 is scheduled for corrective surgery May 2017. 2.All other residents have been	05/24/2017

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	Optometry recommendation for 1 of 1 residents reviewed for vision. (Resident 169) Findings include: The clinical record for Resident 169 was reviewed on 4/12/17 at 9:30 p.m. The diagnosis for Resident 169 included, but was not limited to: chronic obstructive pulmonary disease. An optometry exam dated 2/16/17, indicated Resident 169 was to be referred to an Ophthalmologist regarding bilateral cataracts. An interview was conducted with Resident 169 on 4/12/16 at 2:25 p.m. She reported she had been having problems with her right eye, but had not heard anything regarding when she would be seen by an eye doctor. An interview was conducted with Social Services Director on 4/18/17 at 12:38 p.m. She indicated Resident 169's ophthalmologist referral appointment had not been made. She reported it had been overlooked. 3.1-39(a)(1)		audited for outside referral services and any to be affected by the alleged deficient have been corrected. 3.The ancillary services for vision provides a log after each visit with which resident was seen with any further recommendations &/or outside referrals required. Social Services or designee will review all referrals made by visual ancillary services to make sure appropriate follow up is completed. A weekly meeting will be conducted with nursing to follow-up and validate that appointments and transportation has been accommodated. 4.This POC will be on-going will be discussed monthly at the QAA meeting to identify and trends and need for the further education.	

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F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (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. (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. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a			

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	resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure bladder scans were implemented in a resident's plan of care as ordered for 1 of 1 resident reviewed for hospice. (Resident 123) Findings include: The clinical record for Resident 123 was reviewed on 4/18/17 at 10:30 p.m. The diagnoses for Resident 169 included, but were not limited to: urinary incontinence, dementia without behavioral disturbance and intellectual disabilities. A hospice nursing clinical note dated 4/7/17, indicated "...Aid (sic) reports pt (patient) hasn't voided all shift. Bladder scanned and pt is retaining 255 ml (milliliter). Wrote order to bladder scan q (every) shift and prn (as needed); I & O (in and out) cath (catheter) if (symbol for greater than) 350ml...." A physician order dated 4/7/17, indicated Resident 123 was to receive bladder scans every shift and as needed due to urinary retention. The staff was to in and out cath Resident 123 if there were more than 350 milliliters of urine left in her	F 0315	1. Resident #123 bladder scan was completed as ordered with negative results. Hospice was notified and order was discontinued. 2. All residents have been audited. Those residents found to be affected by the alleged deficient practice have been corrected 3. The nursing staff has been inserviced on how to correctly enter physician orders so that the order will be documented as completed on the MAR as the order was entered incorrectly. . A random audit will be completed on correct order entry three times per week by the Unit managers/designee to ensure compliance. The results will be reviewed at the next day IDT meeting for any needed education. 4. This POC will be on-going will be discussed monthly at the QAA meeting to identify and trends and need for the further education	05/24/2017

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	bladder after scanning. Resident 123's clinical record did not include documented urine residual amounts or bladder scans were being provided. An interview was conducted with Medical Records on 4/18/17 at 12:25 p.m. He indicated he could not locate the bladder scan order on Resident 123's MAR or TAR (Medication Administration Record and Treatment Administration Record) for staff to do. An interview was conducted with the Director of Nursing Services (DNS) on 4/18/17 at 2:50 p.m. She indicated the bladder scan order was missed. She reported she had contacted hospice, and they still want bladder scans to be done by the staff for Resident 123 regarding her retaining urine. 3.1-41(a)(2)			
F 0318	483.25(c)(2)(3)			

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SS=D Bldg. 00	INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to implement a resident's splint use and a resident's bilateral boot splints for 2 of 3 residents reviewed for range of motion. (Resident 10 and Resident 32) Findings include: 1. The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia and contractures. The 3/22/17 Quarterly MDS Assessment indicated Resident 10 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. An interview was conducted with Resident 10 on 4/12/17 at 3:20 p.m. He	F 0318	1a. Resident # 10 no longer resides in the facility 1b. Resident #32 splints have been applied as ordered and placed on C.N.A assignments sheets and care plans. 2. Clinical records have been reviewed of all residents with splints. Those found to be affected by the alleged deficient practice have been corrected. 3. The nursing staff have been inserviced on the correct application of splints. The DON or designee will monitor the application of splints during compliance rounds weekly. Any employee identified as not applying splints per physician order will be inserviced and/or counseled. The Staff Development Coordinator or designees will inservice appropriate personnel of the proper application of splints during	05/24/2017

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	indicated he had a splint for his right hand, wore it the previous night, and should wear it daily. The 4/12/17 Occupation Therapy (OT) Therapist Progress & Discharge Summary indicated, "Splinting: Time...The patient will tolerate right wrist extension for 6 -8 hours 4/7 nights/week with application of functional position splint in order to prevent deformity. Start of Goal Status as of 3/22/17...The patient tolerates right functional position splint for 4 hours. Prior Level as of 4/5/17...The patient tolerates right hand splint for 4 hours when donned. Pt (patient) reports nursing does not don at night and he has had increased pain. End of Goal Status as of 4/12/17...The patient tolerates right hand splint for 6 hours when donned. Pt reports nursing does not don at night and he has had increased pain....Pt has R WHFO (splint) and is able to wear it for 6 hours with no discomfort. Pt requires staff assistance to don splint and is able to remove it mod I with occasional difficulty manipulating straps. OT has discussed and made environmental adaptations in room so pt is better able to reach his personal items....Staff aware of Pt's need for splint application. Pt is able to request this on his own at the time he would like....Pt has met most goals. He		orientation and as needed. The therapy staff has been inserviced on importance of timely documentation of splint orders so nursing can put orders into the EMR, careplan and C.N.A assignments sheets and apply as ordered. The Department Managers will monitor through direct observation on their daily Angel compliance rounds. 4. The results of the rounds will be reviewed at the next QAA meeting for six months or until substantial compliance is achieved	

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	can request splint application in the evenings and is able to remove it mod I....DC (discharge) to LTC (long term care). Pt to wear R (right) splint 6-8 hours in the evening or at night." The April, 2017 physician's orders for Resident 10 were reviewed. There was no order for a splint. Resident 10's care plans were reviewed. There was no care plan regarding contractures or the use of a splint. An interview was conducted with the ADNS (Assistant Director of Nursing Services) on 4/13/17 at 9:17 a.m. He indicated Resident 10 had a contracture to his right hand, but did not receive range of motion services or have a splint device in place. He stated, "He does not have a splint." An observation of Resident 10 was made on 4/17/17 at 2:10 p.m. He was in his wheel chair, in the hallway. He was wearing a splint on his right hand. An interview was conducted with Resident 10 on 4/19/17 at 4:37 p.m. His splint was not on at this time. He stated, "It started off, I would have the splint as much as I can tolerate it. I had it on all night one night. I haven't worn it all			

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	day." An interview was conducted with CNA (Certified Nursing Assistant) #6 on 4/20/17 at 10:06 a.m. She stated, "Sometimes he wears a splint. I've never put it on him." The CNA assignment sheet for Resident 10 was reviewed with CNA #6 at this time. It did not reference the use of a splint. An interview was conducted with CNA #7 on 4/20/17 at 10:19 a.m. She stated, "I've never seen a splint for him, and never put one on him." An interview was conducted with LPN (Licensed Practical Nurse) #8 on 4/20/17 at 9:58 a.m. She stated, "He doesn't have orders for a splint..." An interview was conducted with OT (Occupational Therapist) #9 on 4/20/17 at 10:27 a.m. She stated, "He has a splint....He's supposed to be wearing it all night." An interview was conducted with OT #9 on 4/20/17 at 2:01 p.m. She stated, "I haven't looked into whether he has an order. I vaguely remember writing one for the splint at bedtime....I did this within the last few weeks. There probably should be an order for a splint."			

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An interview was conducted with Resident 10 on 4/20/17 at 3:40 p.m. He stated, "I've had the splint for a few weeks or more. (Name of therapist), another OT, helped me get the splint. I was told I could use it, as I could stand it. I am supposed to take it off from time to time. I didn't have a schedule or anything. It wouldn't bother me now to be on, but I need someone to help me put it on and take it off. No aides or nurse have ever offered to put it on me. The times I have used it, it was therapy that put it on. It would be helpful for staff to offer to put it on me. I'd be fine with it. It can't benefit me, if i'm not using it."

An interview was conducted with CNA 12 on 4/20/17 at 3:46 p.m. She stated, "One of the therapists showed me a few weeks ago how to put it on, but I don't really feel comfortable, because I'm not really sure how to do it, and I don't want to mess up his arm."

An interview was conducted with the Therapy Director on 4/20/17 at 3:50 p.m. He stated, "We wrote an order for the splint today."

The 4/20/17 Physician's Order read, "Late Entry for 4/12/17: Resident to wear (symbol for "right") hand splint apply at

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	bedtime remove when pt gets up in morning." An interview was conducted with the District Nurse (DN) on 4/20/17 at 4:22 p.m. She stated, "We were not aware of the splint orders until today." The District Nurse provided the Application of Removable, Preformed Splints policy on 4/24/17 at 12:12 p.m. It read, "Verify order for: For proper application, if other than manufacturer's instructions. Schedule of application, if not used during all hours of the day." 2. The clinical record for Resident 32 was reviewed on 4/13/17 at 9:30 p.m. The diagnoses for Resident 32 included, but were not limited to: cerebral palsy, hemiplegia and foot drop. A physician order dated 12/7/16, indicated "Orthrosis/foot drop splint to BLE (bilateral lower extremities) on when up in wheelchair every shift...". Observations were made on 4/21/17, of Resident 32 up in his wheelchair without wearing bilateral leg splints at the following times: 8:45 a.m., 10:28 a.m., 11:30 a.m., 12:05 p.m., and 2:03 p.m. An interview was conducted with Certified Nursing Assistant (CNA) 15 on			

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	4/21/17 at 2:06 p.m. She indicated she was Resident 32's CNA. She reported Resident 32 did have leg splints, but therapy took them a way a few weeks ago. An interview was conducted with Physical Therapist 13 on 4/21/17 at 2: 30 p.m. She indicated she had ordered Resident 32 to wear bilateral leg splints when he was up in his wheelchair. She reported the ordered had not been discontinued, and if Resident 32 was up in his wheelchair he should have them on. An observation was made of Resident 32's room with the Therapy Director on 4/21/17 at 2:40 p.m. The Physical Therapist Director had located Resident 32's bilateral leg splints in the bottom of Resident 32's closet. 3.1-42(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -			

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	(1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.			
	Based on interview and record review, the facility failed to have the interdisciplinary (group of facility staff members from various fields) team analyze hazard and accident risk data for potential causes of falls for 1 of 1 residents reviewed for accidents (Resident K). Findings include:	F 0323	1.Resident K unable to determine as this was on complaints survey. 2.All other residents that experience a fall event have the potential to be affected. 3.The Licensed nursing staff have been in serviced on the Accident and Supervision to Prevent Accidents policy and procedure and the importance of conducting neuro checks post unwitnessed fall. The IDT team	05/24/2017

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	1a. The clinical record for Resident K was reviewed on 4/19/17 at 1:45 p.m. The diagnoses for Resident K included, but were not limited to, schizophrenia, anxiety, and anemia. A MDS (minimum data set) assessment, dated 12/2/16, indicated Resident K needed extensive assistance with 2+ people for transfers, extensive assistance with 2+ people for bed mobility and extensive assistance with 2+ people for toilet use. The MDS assessment indicated Resident K had moderate cognition impairment, with a BIMS (brief interview of mental status) score of 12. The Post Fall investigation Reports were requested from the Director of Nursing Services (DNS) on 4/18/17 at 3:15 p.m. The Post Fall Investigation Reports indicated Resident K had falls on the following dates: 1/3/17 1/16/17 1/22/17 2/6/17 2/17 /17. A Late Entry Progress Note, dated 1/17/17 at 7:00 p.m., indicated, "...Found res [resident] sitting on floor between w/c [wheelchair] and toilet. Asked if he was		has been educated on determining causal factors potentially related to the fall event. The following business day the IDT will review the Post Fall investigation and determine root cause of fall and implement appropriate intervention to potentially prevent further falls. The Unit manager/designee will validate that the neuro checks are being conducted. The DNS/designee will audit the fall system weekly to identify any trends, needs for additional education. 4.The results of these audits will be ongoing and reported to the QAA monthly for the committee to make any additional recommendations.	

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	going to use toilet, he nodded his head yes. Body assessment completed, PROM AROM [passive range of motion, active range of motion], moving all extremities as usual. Denies any discomfort. VS [vital signs] and neuro checks WNL [within normal limits]. Family and [name of Physician practice] notified...." A Post Fall Investigation Report for the 1/17/17 fall was not located in the clinical record, nor provided by the DNS above. An Interdisciplinary/Management Team Meeting note related to the fall described above was not located in the clinical record. 1b. A Progress Note, dated 2/6/17 at 3:00 a.m., indicated, "...found on floor this morning at 3am [sic] by aide on side of bed during rounds. No injuries noted. VS and neuros wnl. MD, DHS [Director of Health Services], and family notified...." A Post Fall Investigation, dated 2/6/17 at 3:00 a.m., indicated an unwitnessed fall and Resident K "rolled or slid out of bed", was found on the floor, was lying face down next to the bed, and the resident indicated they were trying to "change positions."			

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	An Interdisciplinary/Management Team Meeting note related to the fall described above was not located in the clinical record. During an interview with the Assistant Director of Nursing (ADON), on 4/24/17 at 9:28 a.m., the ADON indicated the interdisciplinary team/management discusses all falls to analyze the root cause. The ADON also indicated the facility had a "soft file" to track the falls to document discussion, but the Post Fall Investigations and management/interdisciplinary notes in the clinical record were the primary investigations for falls. At 1:24 p.m., on 4/24/17, the ADON indicated he worked in the facility while Resident K resided there. He further indicated Resident K continued to fall and the resident would not be able to explain why he fell. On 4/24/17 at 1:56 p.m., the ADON indicated the facility was unsure if the fall from 1/17/17 and 2/6/17 were analyzed by the interdisciplinary team/management for causal factors and the facility was unable to locate documentation that the interdisciplinary team reviewed the falls from 1/17/17 and 2/6/17.			

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	A policy titled, Accidents and Supervision to Prevent Accidents, dated 4/28/11, was provided by the District Nurse on 4/24/17 at 10:54 a.m. The policy indicated, "...Analysis and Implementation of Interventions 1. Facility staff observe, identify, resolve potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. 2. Staff analyzes hazard and accident risk data for potential cause and designs interventions to mitigate the risk of the hazard...." This Federal Tag relates to Complaint #IN00226056. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--			

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	(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure a resident did not receive a hypnotic medication in excessive dosage for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 4/13/17 at 10:58 a.m. The diagnoses for Resident 17 included, but were not limited to, insomnia. The hypnotic medication use care plan, revised 4/17/17, indicated to administer medications as ordered. The 2/1/17 pharmacy recommendation read, "(Name of Resident 16) is	F 0329	1.) Resident # 16 had no adverse effects from receiving the increased dose for three days. The medication was identified and corrected in Feb 2017 2) The Pharmacy Consultant conducted charts audit to identify any other unnecessary drugs . Any residents found to affected by the alleged deficient practice were corrected. 3) The Staff Development Coordinator will in-service the Licensed nursing staff on unnecessary drugs duplication of orders and how to entry MD orders correctly in the EMR. The Pharmacy Consultant will continue to conduct Drug Regimen Reviews on a monthly basis to identify and report unnecessary drugs to the attending physician. The Director of Nursing,	05/24/2017

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	receiving: Zaleplon (Sonata) (a hypnotic medication) 10 mg QHS (every evening). Federal nursing facility regulations require that gradual dosage reduction (GDR) be attempted at least quarterly for medications used to aid with sleep, unless clinically contraindicated. Per Social Services, a GDR would be appropriate at this time. Recommendation: If appropriate, consider a reduction: Zaleplon 5 mg QHS. If wish to continue current dose, please document reasons of clinical contraindication below to keep the facility within compliance....Physician's Response: I accept the recommendation above, please implement as written." The recommendation was accepted by the nurse practitioner on 2/16/17. The 2/16/17 Physician's Order indicated to discontinue current Zaleplon order and start 5 mg of Zaleplon QHS for a GDR. The 2/16/17 Behavioral Health Services note read, "No sleep quality issues. Will dose reduce the sonata and f/ (follow up) 2-4 weeks to assess response. Med Changes: 5 mg sonata qhs." The 2/18/17 Physician's Order indicated, "Zaleplon Capsule 5 mg Give 5 mg by mouth one time a day for insomnia."		or her designee, will review new medication orders on at least a daily basis to identify and address unnecessary drug issues. 4) The Director of Nursing, or her designee, will monitor through record review (physician orders) and report review (Drug Regimen Review), monthly for three months, then at least quarterly, to assure residents do not receive unnecessary drugs and report result of audit to the monthly QAA committee to determine substantial compliance is met.	

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	The February, 2017 MAR (medication administration record) indicated Resident 16 received a 5mg capsule of Zaleplon at 1:00 a.m. and 9:00 p.m. on 2/22/17, 2/25/17, and 2/26/17. An interview was conducted with the DNS (Director of Nursing Services) on 4/19/17 at 9:29 a.m. She stated, "We had the pharmacy recommendation, and a nurse entered the order. It got entered twice." The Unnecessary Drugs policy was provided by the DNS on 4/19/17 at 10:29 a.m. It read, "The resident's medication regimen is free of any medication used: In excessive dose." 3.1-48(a)(1)			
F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to ensure metal pans were stored in a way that protects them from potential contamination. The facility also failed to ensure the kitchen was maintained in a cleanly fashion. This had to potential to affect 73 residents that dine from the kitchen. Findings include: During an observation at 12:35 p.m., on 4/12/17, white debris and a broken bowl	F 0371	1.Individual residents not identified. 2.No residents were affected by the alleged deficient practice. 3. The Registered Dietitian and Dietary Manager has developed and implemented a cleaning schedule to address areas identified. Finding #1 was corrected on 5/10/17. Pots and pans shelving system was moved to another area and a Plexiglass shield was ordered for the bottom shelf to be placed under the pots and pans to create a barrier. Daily cleaning schedule was implemented and posted in the	05/24/2017

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	was observed under the dishwasher near the corner. A gnat was observed flying around the dishwasher. 2 Sugar packets were observed under the dry storage shelves, along with a white granular substance. Several long metal pans were observed sticking out from a bottom shelf of a shelving system. The shelving was designed with open spaces to the floor underneath. The floor could be visualized through the open spaces, where the metal pans were resting on the shelf. A large, deep metal pan was also observed on the bottom shelf. The shelving was located in a walkway to the pantry and dishwasher. White pieces of debris were noted under the shelving. The Dietician indicated at this time to Dietary Staff that all the metal pans needed to be washed and the items on the shelves needed to be rearranged. During an interview with Cook #26, on 4/12/17 at 12:43 p.m., Cook #26 indicated the long metal pans were used to make items like cookies and cakes. The large deep pan was used to make items like meatloaf. Both types of pans were used once or twice throughout the week. On 4/19/17 at 4:29 p.m., white pieces of debris were observed under the shelving describe above. The long metal pans were		kitchen for staff to sign off daily. Weekly rounds and monthly sanitation rounds will be performed by dietary manager and dietitian. The Dietary Manager and Dietitian inspected the kitchen and developed cleaning/replacement/repair schedules to address areas identified. 4.Results of inspection reports will be taken to monthly QAA meetings to identify any trends or additional education needs that have to be addressed/ conducted. This will be an on-going process	

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	directly over the bottom shelf and the large deep pan was also observed on the bottom shelf. The bottom shelf where the pans were placed was observed with open spaces to the floor underneath. At 4:30 p.m., on 4/19/17, the Dietician indicated all pans that were on the bottom shelf had been washed. The Dietician also indicated the shelving system was on wheels so it could be moved when the area was cleaned and the area was usually mopped instead of swept. On 4/21/17, at 11:50 a.m., the Dietician indicated she had the staff wash the pans because they were sticking out from the shelving instead of directly over it. The Dietician indicated there was possible potential for debris to reach the items on the bottom shelf. At 12:15 p.m., on 4/24/17, Dietary Aide #27 indicated he will sweep in front of and around the shelving, he would pull out the shelving, continue sweeping, and then would mop around the area. During an observation with Dietary Manager #28, on 4/24/17 at 12:20 p.m., a sugar packet from the observation above was noted under dry storage shelves. The same white debris was noted in the corner under the dishwasher and white			

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	pieces of debris were noted under the shelving. The Daily Cleaning Schedule was provided by the Dietician, on 4/21/17 at 11:50 a.m. It indicated, "...Day and Night Aide Wipe area shelves and counter tops...Sweep Floor in tray-line area...Day and Night Dish...Wipe area shelves and counter tops...Sweep and Mop Dish Room... The Retail Food Establishment Sanitation Requirements, dated 11/13/04, indicated, "...Sec 100. "Utensil" means a food-contact implement or container used in the storage, preparation, transportation, dispensing... 410 IAC 7-24-239 Equipment, utensils, and linens Sec 239. (a) Except as specified in subsection (c), cleaned equipment and utensils...shall be stored as follows: (1) in a clean, dry location. (2) Where they are not exposed to splash, dust, or other contamination. (3) at least six (6) inches above the floor. (4) In a manner to prevent overcrowding. (b) Clean equipment and utensils shall be stored as follows: (1) As specified in subsection (a). (2) In a self-draining position that allows air drying. (3) Covered or inverted...."			

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	3.1-19(f)			
F 0372 SS=D Bldg. 00	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly, with the potential to affect 8 of 82 residents in the facility who resided on a 200 hall. (Residents 43, 106, 139, 165, 178, 179, 182, and 183) Findings include: An initial tour of the facility was conducted on 4/12/17 at 12:10 p.m. The 200 hall linen closet was observed with a used pair of latex gloves wadded up with a paper towel on the floor. The following was also observed on the floor: a clean	F 0372	Resident #43, #106, # 139, # 165, # 178, # 179, # 182, and #183 were not affected by the debris located on the floor of the linen closet. The closet was cleaned immediately. The Account Manager will verify that all 6 linen closets are cleaned on a daily basis. The Floor Technician will be responsible for vacuuming out each of the 6 linen closets on a daily basis. The Laundry Aide will verify when stocking linen closet, that each of the 6 linen closets are cleaned and organized. The Account Manager will document that each closet is verified on a daily basis. This will be done utilizing the Linen Closet Verification Spreadsheet. The results of these audits will reviewed monthly at the QAA. This is on-going	05/24/2017

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	fitted sheet, multiple pieces of popcorn, a bottle of empty body wash, a new pack of ted hose, a candy wrapper, and a straw wrapper. An interview was conducted with RN #10 on 4/12/17 at 12:36 p.m. She looked at the items on the floor of the above mentioned linen closet and stated, "Somebody obviously put their trash in there. It's not supposed to be there." The alphabetical list of residents provided by the Administrator on 4/12/17 at 12:30 p.m. indicated Residents 43, 106, 139, 165, 178, 179, 182, and 183 resided on the hall of the above referenced linen closet. An interview was conducted with the District Nurse on 4/24/17 at 4:29 p.m. She stated, "We can't find a policy on garbage or clean linens." 3.1-21(i)(5)		process.	
F 0412 SS=D Bldg. 00	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities			

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	The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to address dental services timely (Resident 127). Findings include: The clinical record for Resident 127 was reviewed on 4/18/17 at 11:45 a.m. The diagnoses for Resident 127 included, but were not limited to, diabetic mellitus, aortic vale replacement, and dementia. During an interview with Family Member	F 0412	F412 I. Resident # 127 was seen by the dentist on 5/4 and no abnormal findings noted and resident is currently not expressing any dental pain. 2. All residents have had a completed dental assessment and those found to be affected by the alleged deficient practice have been corrected or placed on Dentist List 3. Nursing will be in serviced on assessing resident oral status on	05/24/2017

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	#2, on 4/17/17 at 9:39 a.m., Family Member #2 indicated Resident 127 has "bad teeth" and would like for Resident 127 to see the dentist. She further indicated no one at the facility discussed dental services with her. During an observation, on 4/18/17 at 12:20 p.m., Resident 127 was observed with several discolored broken teeth on the bottom. An Admission MDS (minimum data set) assessment, dated 11/8/16, did not indicate any dental concerns. During an interview with CNA #3 and LPN #4, on 4/19/17 at 2:34 p.m., they indicated Resident 127's bottom teeth had been broken and discolored since his admit to the facility. On 4/21/17 at 8:50 a.m., the District Nurse indicated the facility does an oral assessment at admission but it does not address broken teeth or teeth with cavities. If the MDS (minimum data set) assessment was coded incorrectly, the concerns with teeth might be missed unless staff or family bring a concern forward. A Patient Clinical Evaluation, dated 11/1/16, did not indicate any dental		admission , quarterly and PRN. Social Services will be notified of Those residents that are in need of dental . All new admission will be notified of how to obtain dental services. The Social Worker or her designee will maintain a log of residents with a dental referral. The log will include the contacts made, with findings regarding the availability of dentist and facilities providing/accepting Medicaid residents. A weekly meeting will be conducted with nursing to follow-up and validate that appointments and transportation has been accommodated. 4. The Quality Assurance Committee will review and analyze the data monthly for three months and then quarterly thereafter. If deemed necessary, a subsequent plan of action will be developed and implemented. The Administrator is responsible for overall compliance.	

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	concerns. At 10:36 a.m., on 4/21/17, the Assistant Director of Nursing (ADON) indicated the facility does not have a dental consent for treatment for Resident 127 and no dental services have been provided to Resident 127. Dental concerns were usually brought up at admission and care plan conferences. He indicated he had not observed Resident 127's teeth. On 4/21/17 at 10:42 a.m., the ADON indicated Resident 127 does have discolored broken teeth. During an interview with the Social Services Director, on 4/21/17 at 11:19 a.m., she indicated she just started the role of assisting residents with ancillary services. She further indicated she just met Resident 127 recently and noticed concerns with his teeth. She had been trying to get in touch Resident 127's family since she noticed that dental services were not addressed with the family. Dental services were usually addressed at admission and care plan meetings. Resident 127 was admitted on 11/1/16. A Chewing Difficulty care plan, initiated on 11/16/16 and remained current at the time of review, was located in the clinical			

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	record. At 12:05 p.m., on 4/21/17, the MDS Coordinator indicated Social Services Specialist #5 noted his dental issue since there was a care plan developed. Social Services Specialist #5 no longer at the facility. A policy titled, Dental Services, dated 9/21/16, was provided by the District Nurse on 4/24/17 at 10:54 a.m. The policy indicated, "Patients are assisted with obtaining routine dental services and 24-hour emergency dental services...." 3.1-24(a)(1)			
F 0431 SS=D Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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

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	Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure expired insulin was removed from 1 of 3 medication carts on Brookshire unit. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 4/24/17 at 12:30 p.m. The diagnosis for Resident 27 included, but was not limited to: diabetes mellitus type 2. A physician order dated 7/3/16, indicated Resident 27 was to receive 44 units subcutaneously of humalog with each meal. An observation was made of a medication cart for hall 130-139 on 4/24/17 at 11:51 a.m. It included but was not limited to: 2 humalog insulin vials labeled for Resident 27. One of the humalog vials had a do not use after sticker with a written date of 4/12/17. The second humalog vial labeled for Resident 27 had a written open date of	F 0431	1. Resident # 27 was not harmed from the affected the alleged deficient practice. The insulin bottle was disposed of immediately 2. All other residents have the potential to be affected by the alleged deficient practice. A medication cart audit was completed on 5/4/2017 3. Nursing will be in serviced on expiring medications and storage of biological, syringes and needles. A Quality Assurance nurse from the pharmacy conducts a monthly audit. Any identified concerns will be corrected. The DNS or designee will completed audit on the medication carts weekly x3 months. 4. The results of these audits will be presented to the QAA committee for any recommendations monthly. The plan of correction will be on-going.	05/24/2017

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	4/12/17. An interview was conducted with Registered Nurse (RN) 1 on 4/24/17 at 11:55 a.m. She indicated expired insulin should not be in the medication carts. She reported Resident 27's humalog vial labeled do not use after with a written date of 4/12/17, should have been removed. A "Storage and Expiration of Medications, Biologicals, Syringes and Needles" policy revised dated 1/1/13, was provided by RN 17 on 4/24/17 at 12:04 p.m. It indicated, "...This Policy 5.3 sets forth the procedure relating to the storage and expiration dates of medications, biologicals, syringes and needles...Procedure: ...5. Once any medication or biological package is opened, Facility staff should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications....16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals....." 3.1-25(o)			

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F 0441 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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;			

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	(iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure a Resident's catheter tubing remained off the floor during random observations (Resident 11). The facility also failed to maintain an infection control log to adequately monitor, investigate, and analyze infections in the facility. This had the	F 0441	Resident #11 was not affected by the alleged deficient practice and the tubing was adjusted immediately . The wheelchair was evaluated and the resident was placed in a higher wheelchair so that the foley catheter bag does remain off the floor. No resident was affected by the lack	05/24/2017

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	potential to affect 82 of 82 residents in the facility. Findings include: 1. During the following observations, Resident 11's catheter tubing was noted to be on the floor in a common area or hallway: 4/13/17 at 2:47 p.m., 4/13/17 at 3:29 p.m., 4/17/17 at 9:52 a.m., 4/19/17 at 2:00 p.m., 4/20/17 at 11:09 a.m., 4/24/17 at 10:37 a.m. During an observation and interview with RN #1, on 4/20/17 at 11:13 a.m., RN #1 observed Resident 11's catheter tubing on the floor in a hallway. RN #1 indicated at this time, the catheter tubing should not be laying on the floor. At 11:26 a.m., on 4/20/17, RN #1 indicated catheter tubing should not being laying or dragging on the floor for appropriate infection control practices. 2. The infection control logs were provided by the DNS (Director of Nursing Services) on 4/24/17 at 10:54 a.m. There was no information included in the logs for September, 2016 and October, 2016. There were no facility		of Infection Control Log in the months of September and October. 2. Any residents found to be affected by the alleged deficient practice during audits have been corrected 3. Any resident with a foley catheter will be observed during Angel Care Rounds and any deficient practice will be addressed immediately. The Nursing Staff has been in serviced on appropriate foley placement when resident is up in the wheelchair. The facility had employeed a new Staff Development Coordinator (SDC) who has been educated on how to complete the Infection Control Log accurately to include mapping the infections throughout the facility to identify any trends and provide education. The SDC will conduct random infection control rounds daily which will identify any concerns with foley catheter bags not off the floor and any other concerns. Trends will be identified and addressed. 4. The SDC presents the infection Control Log and results of the infection control rounds to the monthly QAA committee for recommendations. This is ongoing process.	

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	maps, representing potential trends in the facility, for September, 2016, October, 2016, December, 2016, January, 2017, February, 2017, and March, 2017. An interview was conducted with the District Nurse on 4/24/17 at 11:27 a.m. She indicated the position responsible for maintaining the infection control logs, the Staff Development Coordinator, was currently vacant. An interview was conducted with DNS on 4/24/17 at 11:28 a.m. She indicated the purpose of tracking infections in the facility was to see if there were any trends. She indicated, typically, the facility would have a map with color coding, as a means of looking for trends in the facility. She reviewed the infection control logs and stated, "I don't see any for September and October (2016). She indicated she was unsure as to whether an effective infection control tracking process was in place in those months, because there was no information available to make that determination. The Infection Prevention and Control Program policy was provided by the District Nurse on 4/24/17 at 12:20 p.m. It read, "The Infection Prevention and Control Program include processes to minimize healthcare associated infection			

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	(HAI) through an organization-wide program. These processes include but are not limited to the: ...Records and identifies community acquired infections and HAIs...Facility designates an Infection Preventionist (IP) to coordinate the infection prevention and control program....Collects, analyzes and provides infection related data and trends to the Infection Prevention and Control Committee as well (sic) share trends with the staff responsible for providing care to the patient." 3.1-18(a) 3.1-18(b)(1)(a)			
F 0514 SS=E Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;			

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	(iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure medication administration records, treatment administration records, physician's orders, and ADL (activities of daily living) logs were documented completely and accurately for 4 of 26 residents reviewed for documentation (Residents 10, 76, 123, 185) Findings include: 1a. The clinical record for Resident 76 was reviewed on 4/20/17 at 2:45 p.m. The diagnoses for Resident 76 included,	F 0514	1a Resident # 76 has had no negative impact from the lack of documentation on the MAR/TAR. Order for waffle boot was discontinued. 1b Resident #10 No longer resides in the facility 1c .Resident # 185 had no negative impact from lack of documentation on MAR/TAR 1d. Resident #123 had no negative impact from lack of documentation on MAR/TAR and ADL documentation	05/24/2017

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	but were not limited to, diabetes mellitus, anxiety, depression, and multiple sclerosis. A Physician's Order, dated 5/26/16, indicated waffled boot to both heels every shift for wound. During the following observations, Resident 76 was observed without waffled boots to either heel: 4/20/17 at 3:35 p.m., 4/20/17 at 4:05 p.m., 4/21/17 at 10:30 a.m., 4/21/17 at 12:30 p.m. During an observation and interview with RN #1, on 4/21/17 at 12:30 p.m., RN #1 indicated she was not able to locate waffle boots in Resident 76 and did not see them on Resident 76, so she will clarify the order. On 4/24/17 at 9:50 a.m., RN #10 indicated Resident 76 no longer had a wound and it had been some time since the wound resolved. RN #10 indicated the waffled boots were not being used as a prevention measure and she forgot to discontinue to the order. 1b. The April 2017 Physician's Orders indicated the following orders: allopurinol 300 mg (milligrams)		2. All residents have the potential to be affected the alleged deficient practice. . 3. Licensed Nurses and C.N.A have been in serviced on timely Electronic Medical Record signage in the MAR/TAR?ADL logs. A daily audit will be completed on the compliance of clinical record MAR/TAR/ ADL log documentation by the Unit manager/designee. Those records found with deficient finding staff with be contacted and corrections will be made. If continued non-compliance is found with any employee is identified, appropriate performance improvement action will be taken. 4. Any findings will be taken to QAA monthly by the DNS for any recommendations. This will be an ongoing process.	

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	(medication for gout) daily, aspirin 81 mg daily, Aubagio 14 mg (medication for multiple sclerosis) daily, Prevacid 30 mg daily, metoprolol 25 mg (medication for hypertension) every 12 hours, baclofen 10 mg (medication for muscle spasms) three times a day. The April 2017 Medication Administration Record (MAR) had no documentation indicating administration for 4/4/17, 4/12/17, 4/13/17 and 4/17/17 for the following medications as ordered above: allopurinol, aspirin, Aubagio, Prevacid, metoprolol at 6:00 a.m., all 4 days, baclofen at 6:00 a.m., all 4 days. During an interview with RN #1, on 4/24/17 at 10:15 a.m., RN #1 indicated the facility was unable to determine why the MAR documentation was not filled out completely as other medications were given those days. 2. The clinical record for Resident 185 was reviewed on 4/21/17 at 2:45 p.m. The diagnoses for Resident 185 included, but were not limited to, chronic			

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	obstructive pulmonary disease, constipation, and hypertension. A Physician's Order, dated 3/30/17, indicated to apply betadine to right heel callous every shift. The April 2017 TAR (treatment administration record) had no documentation indicating the order was completed on the following dates: 4/1/17 evening shift, 4/1/17 night shift, 4/2/17 evening shift, 4/5/17 day shift, 4/7/17 evening shift, 4/9/17 evening shift, 4/9/17 night shift, 4/14/17 night shift, 4/15/17 night shift, 4/16/17 night shift, & 4/17/17 day shift. During an interview with RN #1, on 4/21/17 at 1:43 p.m., RN #1 indicated Resident 185 does not have any wounds, the TAR was not completely filled out, and the order will probably be discontinued. During an interview with RN #1, on 4/24/17 at 10:15 a.m., RN #1 indicated there was no policy to have documentation in the clinical record			

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	155272	A. BUILDING 00 B. WING	04/24/2017

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	filled out completely and accurately, but that was the expectation of staff. 3. The clinical record for Resident 123 was reviewed on 4/18/17 at 10:30 p.m. The diagnoses for Resident 123 included, but were not limited to: urinary incontinence, dementia without behavioral disturbance and intellectual disabilities. A physician order dated 3/29/17, indicated "cleanse left ischium with sterile water, pat dry, skin prep periwound, cover with border foam, every day shift for wound care..." A physician order dated 3/30/17, indicated "....Apply to left ischium topically every day shift for wound care cleanse left ischium with sterile water, pat dry, skin prep periwound, lightly pack with dakins cover with border foam..." A March TAR (Treatment Administration Record) indicated the following days Resident 123's treatment to her ischium were not signed in the electronic TAR as completed: 3/9/17, 3/10,17, 3/16/17, 3/17/17, 3/18/17, 3/19/17, 3/22/17, and 3/25/17. An April TAR (Treatment Administration Record) indicated the following days Resident 123's treatment			

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	to her ischium were not signed in the electronic TAR as completed: 4/3/17, 4/5/17, 4/7/17, 4/8/17, 4/9/17, 4/10/17, 4/11/17, 4/12/17, 4/13/17, and 4/15/17. An interview was conducted with Registered Nurse (RN) 1 on 4/20/17 at 2:35 p.m. She stated the wound treatments to Resident 123 were provided daily by either the facility staff or the hospice staff when they come in to see Resident 123. RN 1 indicated the TAR should be signed off as completed when the treatments are done. 4. The clinical record for Resident 10 was reviewed on 4/12/17 at 3:00 p.m. The diagnoses for Resident 10 included, but were not limited to, paraplegia. The Late Loss ADL logs were provided by the MDS (minimum data set) Coordinator on 4/20/17 at 3:00 p.m. It included entries for 3 shifts from 3/16/17 to 3/22/17. It indicated Resident 10 was totally dependent on one person for transfers on two shifts on 3/16/17, one shift on 3/17/17, and one shift on 3/20/17. There were no entries to indicate transferring ability on one shift on 3/16/17, two shifts on 3/17/17, three shifts on 3/18/17, one shift on 3/19/17, one shift on 3/20/17, one shift on			

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	3/21/17, and 3 shifts on 3/22/17. An interview was conducted with RN (Registered Nurse) #1 on 4/20/17 at 4:04 p.m. She stated, "The ADL logs should be filled out and completed every shift." An interview was conducted with the DN (District Nurse) on 4/20/17 at 4:22 p.m. She stated, "Total dependence of one person is not possible for transfer, only eating." 3.1-50(a)(1) 3.1-50(a)(2)			
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention.	F 9999	**1.The 8 employees records reviewed were re-evaluated and corrected as necessary. If necessary, an tuberculin skin test**	05/24/2017

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	(5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (t) A physician examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care		**was placed. Those employees listed have received dementia and resident rights.** **2. All residents have potential to be affected by an employee with communicable diseases.** **3. The facility has employed a new Staff Development Coordinator. Education has been provided to include tuberculin skin test timing, timing of chest x-ray prior to hire**	

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	workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examination in order to complete a diagnosis. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personal assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review,		**and annual education requirements. The SDC/Designee will bring completed new hire Health/Education/Licensure files to the DNS/Designee for review prior to the employee being released to floor orientation as an ongoing process of this facility. Employee Health/Education/Licensure will be reviewed for completion monthly based on date of anniversary by the DNS/designee prior to QAA as an**	

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	the facility failed to ensure staff members received annual and new hire tuberculin skin testing and a chest x-ray regarding tuberculosis for 4 of 10 employees reviewed. The facility also failed to ensure annual dementia and resident rights inservice training was provided for 4 of 10 employee records reviewed. (CNA 6, CNA 7, CNA 12, RN 16, LPN 20, CNA 23 CNA 24 and CNA 25) Findings include: The Employee Records for CNA 6, CNA 7, CNA 12, RN 16, LPN 20, CNA 23, CNA 24 CNA 25 were reviewed on 4/24/17 at 2:30 p.m. The Employee Records form indicated the following staff, start dates and work status: CNA 6 - 1/10/17 - full time CNA 7 - 9/17/15 - full time CNA 12 - 3/7/17 - full time RN 16 - 3/27/13 - PRN (as needed) 17.50 hours CNA 23 - 8/19/09 - full time LPN 20 - 1/27/15 - full time CNA 24 - 4/3/17 - part time CNA 25 - 6/16/15 - part time The employee personnel files did not include current annual dementia and resident rights training for LPN 20, CNA 23, RN 16, and CNA 7.		**ongoing practice.** **4.All findings will be acted upon immediately and results reviewed in the monthly QAA meeting.**	

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The employee personnel files did not include annual tuberculin skin testing was completed for CNA 6 and CNA 25.

The employee personnel files did not include new hire step 1 or step 2 tuberculin skin testing was completed for CNA 12.

The employee personnel files indicated CNA 24 had completed a chest x-ray on 4/21/17, to rule out tuberculosis.

An interview was conducted with the District Nurse on 4/24/17 at 2:43 p.m. She indicated chest x-rays are normally completed right away. She reported she was unsure the delay to complete the chest x-ray for CNA 24. The Nurse Consultant stated she was unable to locate the staff members' missing documentation in their personnel files regarding annual and new hire tuberculin skin testing, dementia and resident rights annual inservice training.

A Tuberculin Skin Testing was provided by the District Nurse on 4/24/17 at 3:57 p.m. It indicated, "...policy..use a TB risk assessment to determine the risk of transmission of TB in the facility and to determine the frequency of Tuberculin Skin Testing according to their risk

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	unless otherwise specified in State regulations...Procedure 1. Patients and HCWs (health care workers) should receive baseline TB screening upon admission and hire, using two-step TST or a single BAMT to test for infection with M. tuberculosis. a. Exempted from this requirement are: 1) Persons with a documented history of positive TB skin test results, Note: New employees should produce a copy of their positive TST results and chest x-ray or blood test to demonstrate that he/she is free from communicable disease, the employee is referred to County Public Health as the first choice for x-ray services....2.)...new employees (within the initial 2 weeks of employment and prior to any workplace exposure),...B. A single TST skin test may be administered to those with documented evidence of having a negative TB skin test result in the past 12 months. c. A two-step TSTS skin test is administered to those without documented evidence of a negative TB skin test in the past 12 months...Tuberculin Skin Test Documentation. 1. 1. TSTS results are recorded confidentially in the patient's and/or employee's medical record. Annual screens are performed on employees and patients with TST conversion or reaction..."			

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