STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155197	A. BUILDING 00 B. WING	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SANCTUARY AT ST PAUL'S	3602 S IRONWOOD DR SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaint IN00256227 and IN00238302. Complaint IN00256227- Unsubstantiated due to lack of evidence. Complaint IN00238302- Unsubstantiated due to lack of evidence. Survey dates: April 10, 11, 12, 13, 16 & 17, 2018 Facility number: 000104 Provider number: 155197 AIM number: 100266590 Census Bed Type: SNF/NF: 53 SNF: 13 Residential: 113 Total: 179 Census Payor Type: Medicare: 13 Medicaid: 53 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on April 24, 2018.	F 0000		
F 0623 SS=D	483.15(c)(3)-(6)(8) Notice Requirements Before			

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

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Bldg. 00	Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this			

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	section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.			

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	§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to notify the local ombudsman timely of discharges to the hospital or home for 3 of 3 residents reviewed for discharge. (Resident 15, 9 and 71) Findings include: 1. The clinical record for Resident 15 was reviewed on 4/12/18 on 9:28 A.M. The diagnoses included, but were not limited to, atrial fibrillation and Parkinson's Disease. The Notice of Transfer or Discharge, dated 1/18/18, indicated Resident 15 was transferred to the local hospital. The significant change MDS (Minimum Data Set) assessment, dated 3/19/18, indicated Resident 15 was readmitted to facility on 1/26/18 from local hospital.	F 0623	The Plan of Correction constitutes the written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law. St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered for a Desktop Review. Date of Compliance is May 11, 2018. 1. What corrective actions will be accomplished for those residents found to have been affected by the	05/11/2018

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	2. The clinical record for Resident 9 was reviewed on 4/12/18 at 11:31 A.M. The diagnoses included, but were not limited to, congestive heart failure and seizure disorder. The Notice of Transfer or Discharge, dated 3/28/18, indicated Resident 9 was transferred to local hospital. The significant change MDS (Minimum Data Set) assessment, dated 4/7/18, indicated Resident 9 was readmitted to facility on 3/31/18 for acute hospital stay. 3. A clinical record review was conducted on 04/13/18, at 11:02 AM, for Resident 71 and indicated an admission date of 12/28/17. Her diagnoses included, but were not limited to: tinea cruris, cellulitis, fall, hypertension, weakness, and sleep disorder. The MDS (Minimum Data Set) assessment, dated 01/11/18, indicated a BIMS (Brief Interview for Mental Status) score of 10, moderate cognitive impairment. The assessment was coded as a planned discharge assessment, return not anticipated. The notice of transfer or discharge form was not completed. The bed hold notification was not completed and signed by the resident or a representative. The ombudsman notification was not made until after the transfer was completed. During an interview, on 4/12/18 2:20 P.M., the SSD (Social Service Director) indicated facility does not notify ombudsman of hospital transfers and notifies of home discharges every month.		deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: The facility's policy for Ombudsman Notification was immediately updated to include a copy of Transfer Notice being sent to the Ombudsman and document notification in the medical record. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a) The policy "Ombudsman Notification of Discharges" was updated. (Appendix A) b) Social Services will be educated on "483.15 (c)(3) Notification before transfer." (Appendix B) 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The Director of Social Services/designee will review 3random discharges biweekly for compliance with Ombudsman Notification. The Director Social Services/designee will report findings monthly to the Administrator and quarterly at Mission Driven Quality Improvement Committee until such time the MDQI Committee deems	

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	On 4/12/18 at 2:10 P.M., the SSD provided the Ombudsman Notification of Discharges, dated 10/15/17, and indicated this was the policy currently being used by the facility. The policy indicated the Ombudsman would be notified of Involuntary Discharges and Discharges to home. The Ombudsman would be notified monthly by submitting a discharge report. 3.1-12(a)(6)(A)		the process is in compliance. (Appendix C) 5. By what date the systemic changes will be completed: May 11, 2018	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the			

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	resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to develop a thorough base line care plan addressing the use of a PICC line on admission for 1 of 3 residents reviewed for base line care plans. (Resident 40) Findings include: During an interview, on 4/11/18 at 1:43 P.M., Resident 40 indicated she had an infection to her knee and was receiving antibiotics through an iv (intravenous) line. A clinical record review was completed on 4/12/18 at 9:59 A.M., indicating Resident 40 was admitted to the facility on 3/16/18. Her diagnosis included, but were not limited to: sepsis of right knee prosthesis, dementia, diabetes and depression. A MDS (Minimum Data Set) assessment, dated 3/23/18, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13,	F 0655	1. What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: No corrective action. The residents comprehensive care plan is in place. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 100% audit of residents with PICC lines was conducted at the time of the survey. No other residents were affected during chart review of baseline care plans. 3. What measures will be put into place or what systemic changes will be made to ensure that the	05/11/2018

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	cognitively intact. She required extensive assist of 2 staff for bed mobility, transfers, toileting and dressing and 1 staff for eating. She was frequently incontinent of bladder and always incontinent of bowels. Review of current physician orders, dated 3/16/18, indicated the resident was receiving Ceftriaxone, an antibiotic medication via intravenous line for 33 days. A current care plan problem, dated 3/16/18, indicated the problem was Baseline Care Plan. The goal was for initial care needs are met. Interventions included: medication and treatment as ordered, encourage and educate regarding participation in community Life/Therapy groups for socialization, peer support, provide pastoral care visits as needed, therapy services to be provided, social services to be provided, PASARR recommendations to be followed and refer to other admission care plans for additional interventions. The clinical record lacked further care plans specific for the maintained of the PICC intravenous line and the antibiotic use. During an interview, on 4/13/18 at 10:50 A.M., MDS staff indicated the base line care plan included all her care plans for admission, and the interventions of medication and treatments would cover the PICC line. On 4/17/18 at 8:15 A.M., the Assistant Director of Nursing provided the policy titled," Baseline Care Plan", dated 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...1. A baseline care plan will be developed within 48 hours of the resident's admission. 2. The baseline/admission care plan will include information for the provision of		deficient practice does not recur: a) Staff will be educated on the "Baseline Care Plan Policy," (Appendix D) 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON/designee will review 3 admissions weekly to assure that orders were verified and Baseline Care Plans reflect accurate orders. (Appendix E) The DON/designee will review results with the Administrator monthly and quarterly to the MDQI Committee for review and recommendation. The MDQI Committee will continue to monitor until such time the system is deemed to be in compliance. 5.What date the changes will be completed: May 11, 2018	

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	effective person-centered care and include the minimum healthcare information necessary to properly care for each resident immediately upon admission...." 3.1-30(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to ensure an appropriate care plan was in place related to hospice services for 1 of 1 residents reviewed for hospice care (Resident 31). Finding Includes: A clinical record review was conducted, on 04/12/18 at 02:47 PM, for Resident 31 and indicated an admission date of 10/19/17. Her diagnoses included, but were not limited to: cerebral infarct, hypertension, atrial fibrillation, sleep disorder, anxiety, depressive episodes, and palliative care. The MDS (Minimum Data Set) assessment, dated 01/24/18, indicated a BIMS (Brief Interview for Mental Status) score of 13, cognitively intact. Hospice care was indicated as received during the look back period. Care plans indicated plans in place related to hospice status, but did not include the identification of discipline and provider for interventions or how to contact hospice the facility and provider. During an interview, 04/13/18 at 3:52 PM, the	F 0656	1. What actions will be accomplished for those residents found to have been affected by the deficient practice: Care Plan was updated to include contact information of provider facility. (Appendix F) 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: No other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Social Services has been delegated to coordinate services with hospice and will be educated on "Care Planning Related to Hospice Services. (Appendix G) b. 100% of Hospice Care Plans will be reviewed by the ADON/designee on a monthly basis and results will be reported the Administrator monthly and to the MDQI Committee quarterly.	05/11/2018

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	ADON (Assistant Director of Nursing) and the DON (Director of Nursing) indicated they do not include the contact and provider information on the care plans. A policy was provided by the ADON (Assistant Director of Nursing) on 04/13/18 at 1:30 PM, titled "Hospice Program", dated 05/2008, and indicated this was the policy currently used by the facility. The policy indicated "...a coordinated plan of care between the community, hospice agency and the resident-family will be developed and shall include directives for managing pain and other uncomfortable symptoms...." A policy was provided by the ADON (Assistant Director of Nursing) on 04/16/18 at 10:55 AM, titled "Care Planning Process", dated 05/2008, and indicated this was the policy currently used by the facility. The policy indicated "...care plans will be developed with those areas identified as care needs. Individualized interventions will be care planned according to problem areas identified...." 3.1-35(a)		(Appendix H). The MDQI Committee will continue to monitor until such time the system is deemed to be in compliance. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 100% of Hospice Care Plans will be reviewed by the ADON on a monthly basis and results will be reported to the MDQI Committee quarterly. The MDQI Committee will continue to monitor until such time the system is deemed to be in compliance. 5. What date the systemic changes will be completed: May 11,2018	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on record review and interview, the facility failed to obtain treatment orders timely for the use of a PICC line for 1 of 1 residents reviewed for IV (intravenous antibiotics). (Resident 40)	F 0658	1. What actions will be accomplished for those residents found to have been affected by the deficient practice: The dressing changes and measurements were identified and	05/11/2018

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	Findings include: During an interview, on 4/11/18 at 1:43 P.M., Resident 40 indicated she had an infection to her knee and was receiving antibiotics through an iv (intravenous) line. A clinical record review was completed, on 4/12/18 at 9:59 A.M., indicating Resident 40 was admitted to the facility on 3/16/18. Her diagnosis included, but were not limited to: sepsis of right knee prosthesis, dementia, diabetes and depression. A MDS (Minimum Data Set) assessment, dated 3/23/18, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13, cognitively intact. She required extensive assist of 2 staff for bed mobility, transfers, toileting and dressing and 1 staff for eating. Current physician orders, dated 3/16/18, indicated the resident was receiving Ceftriaxone, and antibiotic medication via intravenous line for 33 days. A progress note, dated 3/27/18, indicated the resident was seen by the nurse practioner who noted the picc line dressing was loose and had dried blood on it. A nurses note, dated 3/27/18, indicated IV Access RN would be coming to change the access site device. A treatment record, dated March 2018, lacked documentation of a dressing change and or measurements of the external length of the PICC line. A treatment record dated April 2018, indicated the		corrected on April 8th, 2018. (Appendix I) 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: A 100% audit of current residents with PICC Lines was audited. No other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Staff will be educated on " PICC Line Care, Frequency of Dressing Changes, and Measurement of External Length of Catheter." (Appendix J) b. The CCC will review 100% of admission charts to identify residents with Vascular Access Devices and follow established policy and procedure. (Appendix K). The DON/designee will review 100% of charts to assure compliance. c. The DON will report audit findings and review results with the Administrator and the MDQI Committee quarterly. The MDQI Committee will continue to monitor until such time the system is deemed to be in compliance. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;The	

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SANCTUARY AT ST PAUL'S	3602 S IRONWOOD DR SOUTH BEND, IN 46614

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	dressing change and measurement orders for the PICC line were started on 4/8/18, 24 days after admission. During an interview on 4/16/18 at 12:07 P. M., the Assistant Director of Nursing indicated that the resident did not have the orders for the PICC dressing changes and measurement prior to 4/8/18 and there was no documentation to show the dressing changes and measurements were completed. On 4/13/18 at 4:00 P.M., the Assistant Director of Nursing provided the policy titled," Central Venous Access Device", dated 04/08, and indicated the policy was the one currently used by the facility. The policy indicated..." Measurement external length of catheter baseline and routinely after placement.... On 4/13/18 at 4:00 P.M., the Assistant Director of Nursing provided the policy titled, " IV Site Care and Maintenance", and indicated the policy was the one currently used by the facility. The policy indicated..." Purpose: To prevent local and systemic infection related to the IV site. 1. Dressing changes will be done at established intervals for Vascular Access Devices ...." 3.1-35(g)(1)		DON will report audit findings monthly to Administrator and at MDQI Committee quarterly. (Appendix K). The MDQI Committee will continue to monitor until such time the system is deemed to be in compliance. 5. What date the systemic changes will be completed: May 11,2018	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to assess a resident's change of condition and implement appropriate interventions for one of one residents reviewed for accidents. (Resident 9) Finding includes: The clinical record for Resident 9 was reviewed on 4/12/18 at 11:31 A.M. The diagnoses included, but were not limited to, congestive heart failure and seizure disorder. The significant change MDS (Minimum Data Set) assessment, dated 4/7/18, indicated Resident 9 was readmitted to facility on 3/31/18 for acute hospital stay and had a fall with injury. A potential for injury associated with falls care plan, dated 1/5/18, related to weakness and history of falls and cognitive deficits related to dementia included interventions, but were not limited to, medication review (1/17/18), staff education, orient to surroundings and introduce to other residents, remind to call for assistance and use assistive devices, provide supervision/assistance with transfers, ambulating, and toileting. A care plan for risk for injury related to the diagnosis of a seizure disorder, created 2/27/18, that included interventions, but were not limited to, labs as ordered to monitor therapeutic levels of seizure medications and notify physician if seizure occurs. All interventions dated 2/27/18. The Clinical Note, dated 1/17/18 at 9:22 A.M.,	F 0689	1. What actions will be accomplished for those residents found to have been affected by the deficient practice: Resident expired on April 19, 2018 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: A care plan audit was conducted on all residents that returned from hospital inpatient or ER visit to assure that all care plan updates occurred. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a) The IDT team will be educated on the "Change of Condition and Care Planning Process Policy."(Appendix L) b) Upon return from the hospital/ER, the IDT team will update the care plan and document an IDT note in the medical record. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 100% of care plans for residents that return from the hospital/ER	05/11/2018

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	indicated Resident 9 had a witnessed fall on 1/16/18 while attempting to stand from wheelchair, she had increased confusion with unsteady gait. Resident 9 was currently being treated for pneumonia and had been started on Keppra for seizure activity and it appeared she was exhibiting adverse side effects related to new medication. The Clinical Note, dated 1/17/18 at 12:33 P.M., indicated Keppra was discontinued and resident was started on Depakote 250 (mg) milligrams. The Clinical Note, dated 1/17/18 at 2:23 P.M., indicated Resident 9 required stand by assist with transfers, limited assist with toileting and activities of daily living, and was able to ambulate 264 feet with front wheeled walker. The Clinical Note, dated 3/27/18 at 3:30 P.M., indicated Resident 9 was found sitting at nurse's station having a seizure like episode that lasted 20 seconds, after that she became flaccid and was unresponsive. She was transported to local emergency room. The ED (Emergency Department) Notes, dated 3/27/18, indicated Resident 9 had renal insuffiency in the ED with a BUN of 33 and creatinine of 2.17, consistent with acute kidney disease and dehydration and had received divalproex sodium because her valproic acid was low. Her diagnosis were acute kidney failure, dehydration and seizure with an order for facility to infuse normal saline at 75 milliliters per hour. No updates noted for fall care plan or seizure care plan. No care plan present for dehydration. The Clinical Note, dated 3/28/18 at 12:16 A.M., indicated Resident 9 was found sitting in the		will be audited by the DON/designee to assure that updates are completed. (Appendix E). Results from the audits will be reported to the Administrator monthly and to the MDQI Committee quarterly for review and recommendation. The MDQI Committee will monitor the process until such time the system in deemed to be in compliance. 5. What date the systemic changes will be completed: May 11,2018	

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	dining room having a "seizure like episode" that lasted for 30 seconds, she became cyanotic and was lowered to the floor. She was not responsive the whole time while waiting for the ambulance. The Discharge Summary, dated 4/1/18, indicated Resident 9 was admitted to local hospital on 3/28/18 and discharged on 3/31/18 with discharge diagnoses that included, but were not limited to, witnessed tonic clonic seizures with subtherapeutic valproate level, dehydration and enterococcal urinary tract infection. Resident was placed on seizure precautions including a sitter to monitor her closely as well as neuro-checks. The Clinical Note, dated 4/1/18 at 1:41 A.M., indicated Resident 9 was admitted back to facility with urinary tract infection. She was oriented to all call lights within reach at bedside as well as bathroom and encouraged resident to use for assistance. No updates noted to care plan for risk of injury related to falls or seizure. The Clinical Note, dated 4/1/18 at 2:17 P.M., indicated Resident 9 seemed to be weak and needing more assistance than usual. The Clinical Note, dated 4/1/18 at 10:36 P.M., indicated Resident 9 seemed to be weak and needing more assistance than usual. No updates for increased monitoring or assistance noted. The Clinical Note, dated 4/2/18 at 9:46 A.M., indicated the IDT (interdisciplinary team) discussed hospital readmission and found resident to be at risk for hot liquids due to muscle			

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	weakness. The Clinical Note, dated 4/2/18 at 4:16 P.M., indicated Resident 9 was having involuntary muscle spasms in her face and extremities, decrease in ADLs, not feeding her self and unable to stand, unsteady gait and difficulty swallowing. Physician was notified and new orders for labs, IV (intravenous) fluids, and with any other decline to send resident to hospital. The Clinical Note, dated 4/3/18 at 1:21 A.M., indicated Resident 9 was observed standing in room with IV line being pulled behind her. She was assisted back to wheelchair. The Clinical Note, dated 4/3/18 at 3:03 A.M., indicated Resident 9 was heard calling out of room and reporting she was feeling "dizzy, dizzy, so dizzy" with increased twitching with sporadic involuntary muscle spasms in upper and lower extremities and was sent to local emergency room. The ER (Emergency) Physician Note, dated 4/3/18, indicated Resident 9 presented with altered mental status. The diagnostic impression was altered mental status and possible seizure with subtherapeutic valproic acid (42). The resident was discharged back to facility with plans for close follow up and the staff was given return precautions. The Clinical Note, dated 4/3/18 at 6:47 A.M., indicated Resident 9 was readmitted back to facility with no new orders. No follow up or documentation for close follow up or precautions. No updates noted to risk of injury related to falls			

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	or seizure care plans. The Clinical Note, dated 4/4/18 at 4:21 P.M., indicated Resident 9 was having multiple myoclonic seizures and the physician was notified, a new order for Valium was received. The Clinical Note, dated 4/5/18 at 11:44 P.M., indicated Resident 9 had seizures throughout the shift and had period were she was alert but confused. The Clinical Note, dated 4/5/18 at 2:30 P.M., indicated Resident 9 was not able to speak in complete sentences and was not making much sense. Resident currently laying in bed. The Unplanned Occurrence Report, dated 4/5/18 at 7:15 P.M., indicated Resident 9 was observed on the floor in the hallway. She was face down and laying on her right hand. On assessment, she was unable to lift her right hand even with assistance. She stated it was very painful. The Radiology Report, dated 4/5/18, indicated Resident 9 had an impacted fracture involving the humeral neck. The Clinical Note, dated 4/6/18 at 4:00 A.M., indicated Resident 9 was sent to hospital at 2:00 A.M. The ER Physician Note, dated 4/6/18, indicated Resident presented to ER following a fall and fracture humeral head was confirmed. The Final Report of humerus, dated 4/6/18, indicated Resident 9 was diagnosed with apparent impacted neck fracture of the right humerus with comminuted component involving the humeral			

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	head. Medial displacement distal fracture portion. During an interview, on 4/13/18 at 10:08 A.M., the ADON (Assistant Director of Nursing) indicated Resident 9 probably was not sent back with return precautions as indicated in ER report from 4/3/18. During an interview, on 4/17/18 at 2:22 P.M., the ADON indicated no updates were made to the care plans related to falls and seizures and no clarification was made for close follow up from hospital on 4/3/18. On 4/16/18 at 9:30 A.M., the ADON provided the Fall Prevention and Fall Occurence policy, dated 5/2008, and indicated this was the policy currently being used by the facility. The policy indicates its purpose was to establish a procedure for the prevention and reduction of falls by the assessment and analysis of teh individual elders risk factors and fall history. A fall risk assessment will be completed at the with... d) significant change in condition 3.1-45(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey, and the Investigation of Complaints IN00256227 and IN00238302. Complaint IN00256227- Unsubstantiated due to lack of evidence.	R 0000		

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	Complaint IN00238302- Unsubstantiated due to lack of evidence. Survey dates: April 10, 11, 12, 13, 16 & 17, 2018 Facility number: 000104 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on April 24, 2018.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete the service plan evaluation semi-annually for 2 of 5 residents reviewed for evaluations. (Resident 2 and 7). Findings include: 1. A clinical chart review was completed on 4/17/18 at 11:45 A.M., indicating Resident 2's diagnosis included, but were not limited to: Parkinson's disease, hypothyroidism, hypertension and lewy bodies dementia. The most recent Service Plan evaluation form for Resident 2 indicated the evaluation was completed and signed on 8/4/16 by the Assisted	R 0214	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Service Plans have been updated for Resident 2 and Resident 5. 2. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: A chart review was completed to assure all semi-annual evaluation are current. 3. What measures will be put into	05/11/2018

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	Living Director. During an interview on 4/17/18 at 1:48 P.M., the Director of Nursing for Assisted Living indicated that there were no further Service Plan Evaluation forms completed semi annually for the resident.2. The clinical record review for Resident 7 was conducted on 04/17/18, at 10:00 AM. The record review indicated the only Semi Annual assessments completed were on 01/11/17 and 02/14/18. No additional asessments were available for review. During an interview, on 04/17/18 at 10:30 AM, MR (Medical Records) indicated no other assessments were available. On 04/17/18, at 10:50 AM, a policy related to resident evaluations was requsted, but one was not available.		place or what systemic changes will be made to ensure that the deficient practice does not recur: a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the residents condition or more often as the resident or facility request. See Service Plan Policy. (Appendix M) b)The Assisted Living Director/designee will monitor the semiannual evaluations for timely completion by a monthly review of all due evaluations for the following 90 days. (Appendix N) 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Results of the audits will be review monthly with the Housing Administrator and presented to the MDQI committee quarterly for review and recommendation. The MDQI Committee will continue to monitor the system until such time the committee deems compliance is achieved. 5. By what date the systemic changes will be completed: May 11, 2018	