STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILDWOOD HEALTHCARE CENTER	7301 E 16TH ST INDIANAPOLIS, IN 46219

(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		F 0000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN0000254259 and IN00254606.

Complaint IN00254259 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656.

Complaint IN00254606 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: April 11, 12, 13, 16, 17, 18, 19, 20, 23 and 24, 2018.

Facility number: 000227
Provider number: 155334
AIM number: 100267520

Census Bed Type:
SNF/NF: 143
Total: 143

Census Payor Type:
Medicare: 21
Medicaid: 97
Other: 25
Total:143

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on April 27, 2018

F 0561 SS=D	483.10(f)(1)-(3)(8) Self-Determination			

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

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Bldg. 00	§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to assist a visually impaired resident in choosing his meals, by not reading the menu to him, for 1 of 4 residents reviewed for choices. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed	F 0561	F 561 1.Resident 80 has had his preferences updated and care planned updated as appropriate. His menu is read to him daily for food selection choices for the next day's three meals. Staff assist resident by filling out his select menu daily. 2.All other residents that have	05/23/2018

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	on 4/12/18 at 2:00 p.m. The diagnoses for Resident 80 included, but were not limited to, blindness. The 3/27/18 Quarterly MDS (minimum data set) assessment indicated Resident 80 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. The 11/18/16 care plan for Resident 80 indicated he was legally blind, and to explain all procedures prior to initiation. The 11/18/16 activities of daily living care plan for Resident 80 indicated he required assistance with all of his ADLs related to his blindness. An interview was conducted with Resident 80 on 4/12/18 2:56 p.m. He indicated he did not choose what he ate for meals, as the staff did not read him the daily menu, so he was not able to select what he wanted to eat. An interview was conducted with Resident 80 on 4/17/18 at 12:35 p.m. He indicated he was blind, could not read the menu, and staff did not read it to him. He stated, "I have no idea what I'm getting for lunch today. I didn't get to choose my breakfast today either....I'd like for them to read it to me, so I can choose my meals. This has been going on since I've been here. I only get to choose, if my sister comes to visit and she reads it to me." Resident 80 did not have his lunch room tray at this time. An interview was conducted with Resident 297, Resident 80's roommate, on 4/17/18 at 12:42 p.m. He indicated staff delivered room trays at lunchtime between noon and 1:30 p.m. daily. They would leave the following day's menu for all		the potential to be affected have been assessed to determine if they need assistance with select menus and had their preferences updated as appropriate. 3.All staff has been educated on self-determination that includes but not limited to resident choices and preferences. All residents will be assessed on admission/readmission/significant change and quarterly to determine the level/need of assistance with menu selection and resident preferences. Residents assistance needs will be updated on the care plan and assignment sheets as appropriate. 4.Department heads/Angel care representatives/designee will talk with and complete an audit for assigned residents to ensure their choices, preferences, and required assistance is being met 5 days weekly x 30 days, then 3 days weekly x 30 days, then 2 x weekly as an ongoing practice in the facility. All findings will be brought to the monthly QAPI meeting until 100% compliance is achieved.	

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	3 meals on the lunch tray for the resident to make their selections. The resident would leave their menu selections on the tray, and staff would collect it when the retrieved the tray. Resident 297 did not have his room tray at this time. An observation was made on 4/17/18 at 12:49 p.m. CNA (Certified Nurse Aide) #3 brought Resident 80 his lunch tray. The 4/17/18 lunch menu was on the tray. The menu read, "Please select one item from each category." No selections were indicated on the menu. An interview was conducted with CNA #3 on 4/17/18 at 12:49 p.m. She indicated when she delivered Resident 80's lunch meal, she would read him the following day's menu and checkmark his selections. She reviewed Resident 80's current lunch menu and stated, "Today's ticket isn't filled out." CNA #3 proceeded to give Resident 80 his lunch meal of grilled cheese, salad, and pudding. Resident 80 informed CNA #3 that no one asked him what he wanted for lunch today. An interview was conducted with Resident 80 on 4/17/18 at 12:54 p.m. CNA #3 was no longer in the room. Resident 80 indicated he wanted a cheeseburger, not the grilled cheese he was served, so CNA #3 left to get him a cheeseburger. An observation was made with UM (Unit Manager) #4 on 4/17/18 at 12:57 p.m. Resident 80 was eating a cheeseburger in his room. An interview was conducted with UM #4 on 4/17/18 at 12:58 p.m. She indicated there were no selections made on Resident 80's 4/17/18 lunch menu. If staff read it to him, and he chose his meal, the menu would indicate his selections.			

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	An interview was conducted with the RDCO (Regional Director of Clinical Operations) on 4/17/18 at 12:55 p.m. She indicated staff should read the menu to Resident 80, checkmark his selections, and turn it in. The Routine Resident Care policy was provided by the RDCO on 4/19/18 at 11:32 a.m. It read, "It is the policy of this facility to promote resident centered care by attending to the physical, emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility." 3.1-3(u)(3)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information			

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	for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on interview and record review, the facility failed to encode a subset of items upon discharge for 2 of 4 residents reviewed for assessment. (Resident 1 and 2) Findings include:	F 0640	F 640 1.Resident # 2 and resident #1 no longer reside in the facility. Resident # 2 had her discharge MDS submitted by the MDS coordinator. Resident # 1 had a discharge MDS complete and submitted by the MDS	05/23/2018

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	1. The clinical record for Resident 2 was reviewed on 4/17/18 at 10:30 a.m. The diagnoses for Resident 2 included, but were not limited to, heart failure. He was discharged from the facility on 11/26/17. The 11/26/17 Discharge MDS (minimum data set) assessment indicated it was to be completed by 12/10/17, and was 128 days overdue. An interview was conducted with the RDAR (Regional Director of Assessment and Reimbursement) on 4/17/18 at 10:56 a.m. She indicated the 11/26/17 discharge MDS for Resident 2 should have been submitted 14 days after 11/26/17, but wasn't. She was unsure as to why it was not submitted. 2. The clinical record for Resident 1 was reviewed on 4/17/18 at 10:35 a.m. The diagnoses for Resident 1 included, but were not limited to, dementia. She was discharged from the facility on 11/13/17. The 11/13/17 nurses note for Resident 1 indicated she discharged home, against medical advice, with her sister. There was no discharge MDS in her clinical record. An interview was conducted with the RDAR (Regional Director of Assessment and Reimbursement) on 4/17/18 at 10:58 a.m. She indicated Resident 1 did not have a discharge MDS assessment completed, but should have had one completed. It should have been submitted by 11/27/17. She was unsure as to why a discharge MDS was not completed for Resident 1.		coordinator. 2.A 100% audit for the last 3 months on all discharged residents was completed. No other residents were found to be affected by the deficient practice. 3.The MDS coordinators have been educated on how to complete a discharge MDS and submit it. All discharge residents will have a discharge assessment completed within 14 days after discharge and this assessment will be transmitted/submitted within 7 days of completion. 4.The MDS coordinator/DON/designee will conduct an audit on 5 discharged residents weekly x 30 days, then 3 discharged residents weekly x 30 days, then 2 discharged residents weekly x 30. Regional MDS support to assist with doing random audits of 10 MDS's a month of discharged residents to ensure a discharge assessment was completed and submitted. All finding will be brought to the monthly QAPI meeting and reviewed until 100 % compliance is achieved.	

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure accuracy of a MDS (minimum data set) regarding a resident's contracture for 1 of 1 residents reviewed for range of motion. (Resident 108) Findings include: The clinical record for Resident 108 was reviewed on 4/17/18 at 11:04 a.m. The diagnosis for Resident 108 included, but was not limited to: encephalopathy. Resident 108 was admitted on 2/21/18. An observation was made of Resident 108 on 4/11/18 at 2:15 p.m. Resident 108 was observed with her right hand contracted and no splint. An observation was made of Resident 108 on 4/12/18 at 3:21 p.m. Resident 108 was siting in her wheelchair at the nurse's station. It was observed her right hand was contracted with no splint. An observation was made of Resident 108 on 4/17/18 at 10:00 a.m. Resident 108 was sitting in the wheelchair and her right hand was contracted. An annual assessment dated 2/21/18, indicated Resident 108 has no impairments to her upper extremities. A quarterly assessment dated 3/10/18, indicated Resident 108 has no impairments to her upper extremities.	F 0641	F 641 1.Resident # 108's comprehensive assessment has been modified to reflect accurate coding of her contracture. Resident's plan of care has been updated to reflect appropriately. 2.A 100% audit of all facility residents has been conducted by the MDS coordinators to ensure accurate coding of all residents that had the potential to be affected by the deficient practice. All findings have been corrected by modifying any inaccurate coding on the MDS and updating the plan of care for any residents affected. 3.In-servicing has been completed for the MDS coordinators for accurate coding on the MDS and how to conduct the accurate assessment process of the resident to identify contractures and Range of Motion limitations. The MDS coordinator/designee will assess all residents for contractures/Range of Motion during the residents' assessment period for the MDS. The DON/designee and MDS coordinator will conduct an audit of 5 assessments weekly x 1 month, then 5 assessments every 2	05/23/2018

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	An Occupational Therapy Plan of Care for Resident 108 dated 2/22/18, indicated "...pt (patient) presents with poor activity tolerance, significantly impaired BUE (bilateral upper extremity) strength, rue flexion contracture's, impaired balance, impaired coordination,.. " An interview was conducted with Occupational Therapist 10 on 4/17/18 at 11:00 a.m. She reported Resident 108's whole right arm was contracted even her shoulder, and it had been like that since her admission. An interview was conducted with the Regional Director of Assessment and Reimbursements (RDAR) on 4/17/18 at 3:18 p.m. She stated Resident 108's annual and quarterly assessments were incorrectly coded. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2017, indicated, "...G0400 Functional Limitation in Range of Motion...Coding Instructions for GO400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand);..Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities. Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury..Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury..." 3.1-31(d)		weeks x 1 month, and then 5 assessments monthly x 3 months to ensure accurate coding of contractures/range of motion. Random verification of MDS accuracy will be conducted by the regional MDS nurse to ensure accuracy of the	

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F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to follow up with a recommendation for a BDDS (Bureau of Developmental Disabilities) consultation for 1 of 2 residents reviewed for PASRR (pre-admission screening and resident review). (Resident 74) Findings include: The clinical record for Resident 74 was reviewed on 4/13/18 at 2:07 p.m. The diagnoses for Resident 74 included, but were not limited to, schizophrenia. The 2/2/17 Level II: PASRR/MI (mental illness) Mental Health Assessment read, "She appears to be intellectually impaired and says she was in	F 0644	F644 1.Resident #74's record was reviewed by S.W and resident has now been referred to BDDS. Once seen by BDDS recommendations will be followed. 2. Audit was completed on all resident records that have Level II's to assure that recommendations and referrals have been made and followed. 3.All admissions who have a level II or that need a referral due to diagnosis will be referred to have Level II complete 4.Charts will be audited on all new admits and QAPI meetings	05/23/2018

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	special ed (education) classes all through grade school. At some point in her life she had a head injury of unknown origin which probably compounded her cognitive difficulties....It appears she may need to have a BDDS level II due to possibly having a hx (history) of intellectual disability prior to brain injury....This individual needs the following mental health services, regardless of placement: ...Needs further review-Specify: Rec (recommend) a BDDS consult with possible level II." There was no information in the clinical record to indicate follow up to the recommendation for a BDDS consult. An interview was conducted with SSD (Social Services Director) #9 on 4/18/18 at 3:20 p.m. She indicated she did not believe Resident 74 ever had a BDDS consultation. She called BDDS the previous week and was informed they have no record of Resident 74. SSD #9 indicated she was unsure why there was no follow up with the BDDS recommendation. An interview was conducted withe the RDCO (Regional Director of Clinical Operations) on 4/19/18 at 11:20 a.m. She indicated the facility had no policy in regards to a level 2.		on a monthly basis to be reviewed until 100% compliance is achieved	
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			

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (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 a care plan addressing the care of the central line for 1 of 2 residents reviewed for parenteral nutrition. (Resident Z)	F 0656	F656 1.Resident Z no longer resides at the facility. 2.A 100% audit of all resident careplans has been completed of	05/23/2018

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	Findings include: The clinical record for Resident Z was reviewed on 4/18/18 at 9:04 a.m. The diagnosis for Resident Z included, but was not limited to: failure to thrive. A physician order dated 1/23/18, indicated "change catheter site dressing with transparent dressing with site change, every week and PRN (as needed) with every site change and as needed.." A physician order dated 1/23/18, indicated "change catheter site dressing with transparent dressing with site change, every week and PRN one time a day every MON (Monday) for routine maintenance..." A physician order dated 1/23/18, indicated "change needleless connector every 24 hours with TPN (total parenteral nutrition) one time a day for routine maintenance..." A physician order dated 1/23/18, indicated "if multi lumen catheter, identify lumen designated for parenteral nutrition only. one time only for IV (intravenous) maintenance for 6 months..." There was no care plan in place for Resident Z's central line. An interview was conducted with the Regional Director of Clinical Operations (RDCO) on 4/23/18 at 12:15 p.m. She reported there should have been a care plan in place addressing infection control with Resident Z's central line. A care plan policy was provided by the RDCO on		all other residents that had the potential to be affected by the deficient practice. The careplans have been updated to reflect a well-developed and implemental plan of care that addresses the mental, psychosocial, behavioral, and safety needs of each resident based on diagnosis, conditions, and behaviors. 3.In-servicing has been completed for all nursing staff, MDS coordinator, and IDT on development of the comprehensive careplan and its accuracy to ensure resident individual needs are addressed and appropriate interventions are implemented. 4.The DON/designee will audit 5 careplans weekly x 1 month, then 5 careplans every 2 weeks x 8 weeks, then 5 careplans monthly until 100% compliance is achieved. All careplans will be reviewed for appropriateness and accuracy no less then quarterly for all residents that reside in the facility. All findings will be reviewed in the monthly QAPI meeting until the determination is made that the practice to be in 100% compliance.	

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	4/24/18 at 10:50 a.m. It indicated, "...Plan of Care: Guidelines..Scope:...Policy: 1. A written resident care plan is developed upon admission and is coordinated by nursing services in cooperation with Nutritional Service, Activities, Social Services, Pharmaceutical Services, and other services as indicated..2. The plan of care is a working tool that provides a profile on the needs of each resident, identifies the role of each service in meeting these needs, and the supportive measures each service will use to accomplish the overall goal of care. A. Each plan of care will have identified the resident needs/strengths/problems, along with at least one goal for each. B. Each goal will state the desired outcome and will be resident specific, measurable and will have identified timeframes. 3. Physician orders are considered as part of the POC..." This Federal tag relates to complaint IN00254259. 3.1-35(a)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or			

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	resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to have a discharge summary that included a recapitulation of the resident's stay and a reconciliation of pre-discharge and post-discharge medications for 1 of 1 resident reviewed for facility discharge. (Resident 139) Findings include: The clinical record for Resident 139 was reviewed on 4/18/18 at 2:30 p.m. The diagnoses for Resident 139 included, but were not limited to, cerebral vascular accident. He was admitted to the facility on 9/29/17, and discharged home on 1/16/18. The 10/2/17 care plan for Resident 139 indicated he wished to return home upon discharge. The 1/16/18 nurses note read, "Res (Resident) clean, dry, and prepared for discharge home. All paperwork completed, reviewed, and sent home with res and fiancé...Fiancé removed majority of	F 0661	F 661 1.Resident # 139 no longer resides at the facility. 2.All other residents that reside in the facility and have the potential to be affected by the deficient practice have had a review of their medical record and if appropriate a discharge summary that includes but not limited to a recap of stay, final summary of residents status, reconciliation of all pre-discharge medications with residents post-discharge medications, and a post discharge plan of care have been initiated and will be completed upon discharge from facility. 3.Licensed nurses and the	05/23/2018

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	res's belongings from SNF (skilled nursing facility) yesterday. Remaining belongings are in res and his fiancé's possession at this time. No concerns, SOB (shortness of breath), s/s (signs/symptoms) of distress noted/reported at this time. All medications sent with res and fiancé at this time. Res and fiancé encouraged with follow up with PCP (primary care physician) ASAP (as soon as possible) within the next 2 weeks. Res and fiancé encouraged to call SNF with any questions or concerns. Res discharged home via family vehicle accompanied by fiancé and fellow loved one at this time." A discharge summary that included a recapitulation of Resident 139's stay and a reconciliation of his pre and post discharge medications could not be located in the clinical record. An interview was conducted with the RDCO (Regional Director of Clinical Operations) on 4/19/18 at 11:10 a.m. She indicated Resident 139's discharge summary probably did not include a recapitulation of his stay that included his course of illness, treatment, therapy, laboratory and radiology information, or consultation results. She indicated there was no reconciliation of his medications either. The Transfer and Discharge policy was provided by the RDCO on 4/19/18 at 11:32 a.m. It read, "Discharge Summary: When a discharge is anticipated, facility will develop a discharge summary that includes, but is not limited to, the following: 1. Summary of Stay i. A summary of the resident's stay that includes, but is not limited to: 1. diagnoses 2. course of illness/treatment or therapy 3. pertinent lab 4. radiology 5. consultation results....Medication Reconciliation		Interdisciplinary Team have been educated on the Discharge Summary policy and procedure that includes but not limited to a recap of stay, final summary of residents status, reconciliation of all pre-discharge medications with residents post-discharge medications, and a post discharge plan of care. Education has been provided to licensed nurses to provide an order summary report upon discharge that distinguishes pre-discharge medications and post-discharge medications. The DON/designee will identify resident(s) that is due to discharge in the daily clinical meeting Monday through Friday and a review of the discharge summary will be completed to ensure a recap of stay, final summary of residents status, reconciliation of all pre-discharge medications with residents post-discharge medications, and a post discharge plan of care are included in the discharge summary every day Monday through Friday. On Friday's the DON/designee will identify resident(s) that are scheduled to discharge on Saturday/Sunday and an audit of the discharge summary will be completed on the Friday prior to discharge. This will be an on-going facility practice. 4.The DON/designee will conduct an audit of 3 discharged	

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	i. Reconciliation of all pre-discharge medications with the resident's post-discharge medications will include: 1. Prescribed/Prescription Medication 2. Over-the-counter Medication." 3.1-36(a)(1)		residents medical record weekly x 2 months, then 3 discharged residents medical record every 2 week x 2 months, then 5 residents medical record monthly x 3 months or until 100% compliance is achieved. All findings will be brought to the monthly QAPI meeting until 100% compliance is achieved.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(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. §483.25(c)(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 coordinate a restorative nursing program for 1 of 4 residents reviewed for positioning and mobility. (Resident 74)	F 0688	F 688 1.Resident #74 has been evaluated by Occupational therapy and is currently on therapy caseload for splinting and Range of Motion. 2.All other residents that have	05/23/2018

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	Findings include: The clinical record for Resident 74 was reviewed on 4/11/18 at 11:00 a.m. The diagnoses for Resident 74 included, but were not limited to, muscle weakness. The 1/16/18 physician's order indicated for OT (occupational therapy) to evaluate and treat. The 1/17/18 OT evaluation, conducted by OT #7, read, "Therapy Necessity: Skilled OT not necessary at this time....has RNP's (restorative nursing programs) for splinting and wc (wheel chair) positioning and is total A (assist) at baseline for self care tasks...Pt (Patient) previously had splinting program completed by staff for B (bilateral) hands using blue and orange carrot orthosis, which pt tolerated 4-6 hours....Discharge Plans: Remain in this SNF (skilled nursing facility) with continued total care and RNP's (restorative nursing program) for orthotic wear and positioning....Rehab Potential: Poor due to: ...Currently has RNP's for splinting and wc positioning." The 1/18/18 physician's order indicated to discharge from skilled OT services, evaluation only. An observation of Resident 74 was made on 4/11/18 at 11:19 a.m. Her left hand was clenched. She was not wearing splints, nor were any orthosis devices in place. An observation of Resident 74 was made on 4/12/18 at 11:11 a.m. Her left hand was clenched. She was not wearing splints, nor were any orthosis devices in place.		the potential to be affected have been assessed for a decrease in their Range of Motion/Mobility to determine the need for therapy screen/evaluation and/or restorative program. 3. Residents will be assessed on admission/readmission/significant change, quarterly, and PRN to identify if there is a decrease in Range of Motion/Mobility. Any resident noted to have a decrease in Range of Motion/Mobility will be referred to the appropriate therapies as needed or will have a restorative program developed and implemented to meet the needs of the residents and maintain their highest level of function and independence. Nursing staff and therapy have been educated on monitoring for patients at risk for decreased Range of Motion/Mobility. 4.DON/Unit Managers/Therapy Director/Designee will assess residents to ensure that if resident is at risk for a decline in Range of Motion/Mobility a therapy screen/evaluation was conducted and appropriate therapies/restorative program was initiated. An audit of 10 residents weekly will be completed to monitor for the need of therapy services/restorative program for 30 days, then 10 residents every 2 weeks, then 10 residents monthly x 2 months. All findings will be	

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	An observation of Resident 74 was made on 4/18/18 at 3:20 p.m. Her left hand was clenched. She had a bandage on the palm of her left hand. She was not wearing splints, nor were any orthosis devices in place. An observation of Resident 74 was made on 4/19/18 at 12:10 p.m. Her left hand was clenched. She had a bandage on the palm of her left hand. She was not wearing splints, nor were any orthosis devices in place. An interview was conducted with CNA (Certified Nursing Assistant) #5 on 4/19/18 at 12:12 p.m. She stated, "She (Resident 74) doesn't use splints or anything. She has an area on her hand and wears like a bandage, because her nails dig in it." An interview was conducted with UM (Unit Manager) #6 on 4/19/18 at 12:16 p.m. She stated, "She doesn't wear any palm protectors or splints, just bandages in her hands, because of her nails. She has an area inside of the palm of her hand." UM #6 indicated the TD (Therapy Director) would have more information. The 4/8/18 physician's order indicated to cleanse left hand with normal saline and pat dry. Apply bacitracin to left palm and cover with foam dressing every day shift for open area. An interview was conducted with the TD on 4/19/18 at 2:10 p.m. The TD reviewed the restorative nursing program binder, and pulled the 2/20/17 restorative nursing splinting program form for Resident 74. The TD indicated this was the most recent restorative nursing program in place for Resident 74. If it were no longer in place, it would be because nursing stopped it. The TD was informed nursing referenced having no		brought to the monthly QAPI meeting until 100% compliance is achieved.	

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	knowledge of a splinting or orthosis restorative nursing program for Resident 74. The 2/20/17 restorative nursing splinting program form for Resident 74 read, "Resident Specific Goals: To prevent joint contractures on left hand as well as decrease risk for skin breakdown. Number of days per week: 7 days/wk (week). Number of weeks: 12 weeks. Plan: Type of device and location of application: carrot finger orthosis. Application Instructions: between palms and fingers of left hand. Wearing schedule: 4-6 hours per day." An observation was made on 4/19/18 at 2:18 p.m. with the TD. Resident 74 was lying in bed, holding onto a blanket with her left hand. The TD stated, "I've never seen her do that before . Maybe we (therapy) need to pick her back up." Resident 74 was not wearing splints, nor were any orthosis devices in place. An interview was conducted with the TD and UM #6 on 4/19/18 at 2:20 p.m. UM #6 indicated she'd never seen Resident 74 with carrots or anything in her hands since she'd been on the unit (since 12/22/17.) The TD indicated she was unsure what exactly was being referenced in the 1/17/18 OT evaluation, conducted by OT #7. The TD indicated if the carrots weren't working out, therapy would want to know. An interview was conducted with OT #7, the RDCO (Regional Director of Clinical Operations), the TD, and UM #6 on 4/19/18 at 3:05 p.m. OT #7 indicated Resident 74 had a cone for her left hand in January, 2018, and he saw her with it. OT #7 indicated the restorative nursing program in place at the time of his 1/17/18 OT evaluation was the 2/20/17 restorative nursing splinting program, but			

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	was unaware it was written for only 12 weeks. OT #7 indicated he thought Resident 74 was still using the cone, and the 12 week term was overlooked, when he did his 1/17/18 OT evaluation. The RDCO indicated the 2/20/17 restorative program was null and void, and there was no restorative nursing plan in place, as therapy never developed one, and nursing was never given one. 3.1-42(a)(2)			
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to dispose of an used insulin syringe timely. This had the potential to affect 1 of 1 residents in the vicinity of the syringe during a random observation (Resident 3). Findings include: The clinical record for Resident 3 was reviewed on 4/13/18 at 11:17 a.m. The diagnoses for Resident 3 included, but were not limited to, diabetes mellitus and anxiety. The April 2018 Physician's Orders indicated to inject Glargine solution (insulin) twice a day and Lispro insulin per the sliding scale with meals.	F 0689	1.Resident #3 was not harmed aby the deficient practice and no longer resides in the facility hazards. No other residents were identified as being affected by the deficient practice. 2.All other residents that have the potential to be affected by the deficient practice have had a survey of their environment to ensure they are free from hazards. 3.All licensed nurses have been educated on accidents, hazards, supervision, and devices. Education included but was not limited to proper disposal of	05/23/2018

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	During an observation, on 4/13/18 at 9:37 a.m., a small syringe without any liquid in the syringe was noted on Resident 3's bedside table. During an interview with LPN #1, on 4/13/18 at 9:39 a.m., LPN #1 indicated she administered insulin to Resident 3 about an hour ago, around 8:30 a.m. She indicated she will remove the syringe immediately, and she went to dispose of the syringe at that time. On 4/17/18 at 11:29 a.m., the Regional Director of Clinical Operations (RDCO) indicated syringes should be discarded after use due to safety reasons. A policy titled, Bloodborne Exposure Plan, last dated 10/12/17, was received from the RDCO on 4/17/18 at 2:16 p.m. It indicated, "...Needles or other contaminated sharps shall be discarded immediately in a container that is closable, leak-proof, puncture resistant box and not overfilled...." 3.1-45(a)(1)		needles and other potential hazards. 4.Department heads/Angel care representatives/designee will conduct an audit of assigned residents environment to ensure area is free from hazards. This audit will be conducted 5 days weekly x 30 days, then 3 days weekly x 30 days, then 2 x weekly as an ongoing practice in the facility through the facilities Angel care program. All findings will be brought to the monthly QAPI meeting until 100% compliance is achieved.	
F 0825 SS=D Bldg. 00	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-			

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	§483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on interview, and record review, the facility failed to timely provide an OT (occupational therapy) evaluation for 1 of 4 residents reviewed for positioning and mobility. (Resident 74) Findings include: The clinical record for Resident 74 was reviewed on 4/11/18 at 11:00 a.m. The diagnoses for Resident 74 included, but were not limited to, muscle weakness. The 4/8/18 nurses note for Resident 74 read, "New order noted from MD, 1) OT to eval (evaluate)/tx(treat) as indicate 2) Skin prep to right/left heel for prevention, 3) Cleanse left palm with NS (normal saline) and pat dry, apply bacitracin and cover with foam dressing, change Q (every) day shift r/t (related to) laceration. POA (Power of Attorney) aware, continue observing." The 4/8/18 physician's order indicated for OT (occupational therapy) to evaluate and treat as indicated. The most recent OT evaluation was provided by the RDCO (Regional Director of Clinical Operations) on 4/19/18 at 11:00 a.m. It was dated	F 0825	F825 1.Resident #74 has been evaluated by Occupational therapy and is currently on therapy caseload. 2.All other residents that have the potential to be affected by the deficient practice have had a review of their medical record for any therapy orders that had not been acknowledged and initiated. No other residents were found to be affected by this deficient practice. 3.Education has been provided to the therapy department on timeliness of order initiation. The DON/designee will print off all new therapy orders from the previous day/days Monday-Friday and present them to the Therapy Director/designee in the daily clinical meeting. All orders will be reviewed the following business day to ensure they have been initiated.	05/23/2018

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	1/17/18. There was no information in the clinical record to indicate the 4/8/18 order for an OT evaluation and treatment was addressed. An interview was conducted with OT #7, the RDCO (Regional Director of Clinical Operations), the TD, and UM (Unit Manager) #6 on 4/19/18 at 3:05 p.m. The TD indicated she was unaware of the 4/8/18 OT order to evaluate and treat. The RDCO indicated the TD had access to the 4/8/18 order for OT evaluation and treatment and was supposed to address it. 3.1-23(a)(1)		4.The DON/designee will complete an audit of all therapy orders to ensure initiation. All therapy orders will be reviewed for initiation 5 days weekly x 30 days, then 3 days weekly x 30 days, then 2 x weekly x 30 days. All findings will be brought to the monthly QAPI meeting to ensure 100% achievement.	
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,			

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	155334	A. BUILDING 00 B. WING	04/24/2018

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	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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			

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	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 accurate documentation of a resident's care plan for 1 of 41 residents reviewed for documentation. The facility also failed to ensure a clinical record was accurate and complete for 1 of 6 residents reviewed for unnecessary medications. (Resident 54 and Resident 82) Findings include: 1. The clinical record for Resident 82 was reviewed on 4/20/18 at 11:00 a.m. The diagnoses for Resident 82 included, but were not limited to, dementia with behavioral disturbance. The 3/26/18 care plan for Resident 82, created by SSD (Social Services Director) #9, read, "(Name of Resident 82) has mood problem actual r/t (related to) schizophrenia; may have delusional thinking and or visual and auditory hallucinations; resident may yell out and or have agitation. The April, 2018 physician's orders, the 4/11/18 behavioral progress note, and 2/21/18 Quarterly MDS (minimum data set) assessment for Resident 82 did not indicate a diagnosis of schizophrenia. An interview was conducted with SSD #8 on 4/20/18 at 11:25 a.m. He reviewed Resident 82's clinical record and indicated he did not see a diagnosis of schizophrenia. An interview was conducted with SSD #9 on 4/20/18 at 11:34 a.m. She indicated Resident 82 did	F 0842	1.Resident #82 has had her plan of care reviewed and corrected for the accurate and current resident diagnoses. The diagnosis of schizophrenia was removed from the plan of care and updated with the appropriate diagnosis of hallucinations. Resident # 54 has had a complete review of medication orders by the physician and orders have been clarified and corrected to reflect the accurate orders for the resident. 2.All other residents that have the potential to be affected by the deficient practice have had a complete review of their plan of care to ensure the plan of care reflects accurate diagnosis and an accurate medical record. All residents have had a review of the current orders on profile and corrected to reflect an accurate medical record. 3.Licensed nurses and the Interdisciplinary Team have been educated on ensuring residents have a complete, accurately documented, readily accessible and systematically organized medical record. This includes but is not limited to accurate	05/22/2018

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	not have a diagnoses of schizophrenia, and the 3/26/18 care plan referencing schizophrenia was a mistake. 2. The clinical record for Resident 54 was reviewed on 4/23/18 at 9:04 a.m. The diagnosis for Resident 54 included, but was not limited to: pruritus. A physician order dated 9/2/17, indicated Resident 54 was to receive triamcinolone acetonide 0.1% cream every shift. A physician order dated 3/15/18, indicated Resident 54 was to receive trimcinolone acetonide 0.1% cream twice daily. The March Medication Administration and Treatment Record indicated Resident 54 received trimcinolone acetonide cream every shift. The April Medication Administration and Treatment Record indicated Resident 54 received trimcinolone acetonide cream every shift. An interview was conducted with the Regional Director of Clinical Operations (RDCO) on 4/24/18 at 10:55 a.m. She reported the staff had clarified the order, since Resident 54 was already receiving this medication every shift. The staff was ordered to keep the trimcinolone every shift and not to decrease the medication to twice a day. The staff should have documented the information in the clinical record and had not. 3.1-50(a)(2)		diagnosis in the plan of care and correct physician orders that are reflected and documented in the residents' medical record. 4. The DON/designee and IDT will review the medical record of the residents to ensure it is complete, with accurately documented information, that it is readily accessible and systematically organized. An audit tool will be utilized to ensure this practice is in place and the medical record is free from erroneous information. The DON/designee will perform a complete audit of the medical record for 5 residents weekly x 2 months, then 5 medical records every 2 weeks x 2 months, then 5 medical records monthly x 3 months until 100% compliance is achieved. All findings will be brought to the QAPI meeting on a monthly basis until 100% compliance is achieved.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for			

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	residents, staff and the public. Based on observation and interview, the facility failed to maintain a resident's room and privacy curtain in a cleanly fashion for 2 of 5 reviewed for environmental concerns (Residents 10 & 81). Findings include: 1. During an observation of Resident 81's room, on 4/12/18 at 9:58 a.m., a hand sized area of tan liquid residue was noted near the head of the Resident 81's bed, underneath a tube feeding canister that was hanging from an IV pole. Several fist sized spots of tan liquid residue were also observed near 81's nightstand. On 4/13/18 at 9:33 a.m. and on 4/17/18 at 9:00 a.m., the areas of tan liquid residue were observed in the same places as noted above. At 10:33 a.m. on 4/18/18, the areas of tan liquid remained as noted above and a small flying insect was noted to be flying in the area of the tan liquid residue. During an interview with LPN #2, on 4/18/18 at 11:45 a.m., she indicated she just had housekeeping in Resident 81's room to clean up the tan liquid residue. 2. During an observation of Resident 10's privacy curtain, on 4/16/18 at 1:47 p.m.,. the privacy curtain surrounding Resident 10's bed, was noted with white debris and white smears all along it. One area of white liquid residue was hand sized. During an observation 4/20/18 at 11:20 a.m., Resident 10's privacy curtain was noted with the same white liquid residue/smears all along it as	F 0921	F921 1. Floor underneath tube feeding and spots of tan liquid were cleaned and mopped 2.All resident who have feeding tubes have the potential to be affected by this practice. Spilled spots will be cleaned up and floor mopped. All areas where residents have feeding tubes were checked and any spills were immediately cleaned. Housekeeping supervisor was given a list of all resident rooms that have feeding pumps. Housekeeping supervisor will mark these rooms on the housekeeping floor care schedule so housekeeper can check the room at a minimum of twice per day to check for any spilled feeding and to clean floor if needed. 3.Housekeeping staff will check all rooms of residents with feeding pumps at a minimum of twice daily and clean any spilled feedings. Housekeeping supervisor will check resident rooms identified with feeding tubes at the beginning and end of each shift to assure that there is no dried feeding on the floor. All residents with privacy curtains around their beds have the potential to be affected. Curtain was removed, laundered and hung back up. Staff have been reinserviced as to reporting when curtains are soiled and need to be	05/23/2018

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	noted above. During an interview with the Housekeeping Supervisor, on 4/20/18 at 11:22 a.m., he indicated curtains were routinely laundered. Staff were supposed to communicate with his department when privacy curtains were in need of laundering, if it was before the scheduled maintenance. Curtains were to be replaced immediately when they were dirty. 3.1-19(f)		taken down to be cleaned between regular routine laundering. Housekeepers are to check privacy curtains daily to see if they are soiled. If soiled they must be taken down, cleaned and rehung. Housekeeping supervisor will do rounds weekly to check all privacy curtains to assure they are clean. Laundering schedule will be followed for routine cleaning of privacy curtains. 4. Housekeeping supervisor will report to QUAPI committee on rounds of checking the Privacy Curtains in each room on a monthly basis until 100% compliance is achieved All privacy curtains will be checked and cleaned by 5/18/20	