STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	08/31/2016

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey- Substandard Quality of Care- Immediate Jeopardy. Survey dates: August 23, 24, 25, 26, 29, 30, and 31, 2016 Facility number: 000383 Provider number: 155721 AIM number: 100289610 Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 8 Medicaid: 32 Other: 4 Total: 44 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on September 2, 2016	F 0000	This plan of correction constitutes written allegation of compliance. However, submission of this plan of correction is not an admission that a deficiency exits. This plan of correction is submitted to meet requirement established by the state and federal law.	

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

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F 0156 SS=D Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of			

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	charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.			

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	The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to inform a resident, in writing, of her rights and all rules and regulations governing resident conduct and responsibilities, items and services included in the facility under the State plan, items and services offered with amounts, a description of legal rights, and information of her right to accept or refuse treatment and formulate an advanced directive for 1 of 6 residents reviewed for personal funds. (Resident #44) Findings include: The clinical record for Resident #44 was reviewed on 8/23/16 at 2:00 p.m. The diagnoses for Resident #44 included, but were not limited to, paranoid schizophrenia and dementia. She was admitted to the facility on 6/29/16 from another extended care facility. An interview was conducted with Family Member #20 on 8/24/16 at 10:05 a.m. She indicated Resident #44 was on	F 0156	**F 156 Notice of Rights, Rules Service Charges** It is the policy of Lawrence Manor to inform the resident both orally and in writing in a language that the resident understands of his rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility. All residents have the potential to be affect ted, however no other residents were affected; Resident #44 information has been reviewed by the social service director and the Business office manager. The Social Service Director has reviewed the resident "s admission packet, the family member has been contacted including the family member that is the POA for this resident. Resident # 44 admission papers have been completed with all information signed and placed into the resident's records. The resident's POA has return the documents and forms with a copy for POA'S record. **Other residents had the potential to be affected by this finding will be identified by:**	09/30/2016

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	Medicaid, and staff did not provide a list of services and items that Resident #44 would and would not be charged for. She stated, "As a matter of fact, I asked them if there was anything I needed to sign, and they said I didn't need to sign anything." An interview was conducted with the BOM (Business Office Manager) on 8/30/16 at 3:47 p.m. She indicated she usually kept a copy of residents' admission packets, but did not have a copy of Resident #44's admission packet. She stated, "I don't have any information on her." The BOM provided a blank copy of a resident admission packet on 8/31/16 at 12:04 p.m. It included the following: Civil Rights information with signature page, Grievance Procedures with signature page, ancillary services consent with signature page, privacy practices information with signature page, release form with signature page, resident preferences form, smoking policy with signature page, admission and payment agreement with signature page, assignment of insurance benefits and Medicare benefits with signature page, code classification form with signature page, consent for release of information, authorization for treatment, general		All other residents have the potential to be affected by this finding however no other residents were affected. All residents' admissions packets have been identified using admissions audits. Additional recommendation provided by facility consultants for compliance. Weekly audit reviews for new admissions presented to the Quality Assurance. **Measures and systemic changes put into place to assure deficit practice do not recur are as follows:** All preadmissions packets reviewed by the administrator prior to admission, the interdisciplinary teams review the completed admission packet at each daily quality assurance meeting. These practices have been implemented to ensure the deficient practice does not recur. **Corrective Actions will be monitored to ensure compliance by**: The social service director will be responsible for the completed admission packet. The business office manager with the administrator to present monthly to the Quality Assurance for the next 6 months.	

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	consents, general stay information, health care consents, personal physician authorization, restraint policy, consent for flu and pneumonia vaccine, Medicare secondary payer form, authorized representative for health coverage form. An interview was conducted with the Social Services Director (SSD) on 8/30/16 at 3:52 p.m. She indicated she completed Resident #44's admission packet with Family Member #20 at the facility, but couldn't remember when, and tried to complete admission packets the day of or after admission. She reviewed Resident #44's clinical record, and did not know why Resident #44's admission packet was missing. On 8/30/16 at 4:00 p.m., the SSD left Family Member #20 a voicemail regarding Resident #44's admission paperwork. On 8/31/16 at 9:54 a.m., a telephone interview was conducted with Family Member #20. She indicated she spoke with the SSD the previous day, and stated, "She is putting all admission forms in the mail today. I'm going to sign them and fax them back. About a week after my aunt was there, they contacted me over the phone, and I gave my consent for something, not sure whether it was for her admission or just that I was her power of attorney....In fact,			

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	they never asked me my address, because she (SSD) said they didn't have it....I did ask them, when I was there on 8/2/16. I asked staff if there was anything I needed to sign, and they said no. I knocked on the administrator's door, and asked if there was anything I needed to sign or if they needed copies of my POA (power of attorney) papers and they said no." 3.1-4(a) 3.1-4(f)(1) 3.1-(f)(1)(A) 3.1-(f)(1)(B) 3.1-4(f)(3) 3.1-(4)(j) 3.1-(4)(j)(1) 3.1-(4)(j)(2) 3.1-(4)(j)(3))			
F 0164 SS=E Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a			

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	private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, interview, and record review, the facility failed to provide privacy by not having a bathroom door for 1 of 2 residents reviewed for privacy, (Resident #54), and failed to maintain privacy of clinical records by leaving a Treatment Administration Record (TAR) in a common area without staff present. This had the potential to affect 27 of 44 residents that reside on that unit. Findings include: 1. During an observation, on 8/23/16 at 2:58 p.m., two books labeled TAR (Treatment Administration Record-records of resident's treatment	F 0164	F 164 Personal Privacy Confidential of Records It is the policy of the Lawrence Manor the facility to provide the resident the right to personal privacy and confidential of his or her personal and clinical record. **Corrective Action Taken Related to this Finding** The Facility has implemented corrective action to the Qualified Medication Aide. The facility also retrained the nursing/facility staff on Protected Health Information and the HIPAA Privacy Rule.	09/30/2016

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	orders) were observed in the back dining room on a table in the middle of the room. The books were visible from the hallway. No staff were in the area or within eyesight. At 3:03 p.m., on 8/23/16, Resident #13 rolled into the dining room with his electric scooter. Resident #13 was observed next the TARs. Resident #13 annual MDS (minimum data set), dated...,indicated Resident #13 had a BIMS (brief interview of mental status) score of 15, which was indicative of no cognitive impairment. A staff member was observed going into the back dining room and adjusted Resident #13's urine collection bag. The staff member left the area and the books remained on the table in the back dining room. During an observation with QMA #1, on 8/23/16 at 3:11 p.m., QMA #1 indicated the TARs should not be in an accessible location without any staff in the vicinity due to patient privacy. QMA #1 picked up the books and returned them to the Front Nurse's Station. A policy titled "HIPAA", dated 9/1/14, was received from the Regional Director of Clinical Operations on 8/25/16 at 4:56 p.m. The policy indicated, "The policy of this Facility is to ensure, to the extent possible, that PHI [Protected Heath Information] is not intentionally or		Resident #54 now has a Bathroom Door II. **Other Residents with Potential to be affected by this finding will be identified by**: All residents had the potential to be affected by this alleged deficient practice III. **Measures and Systemic Changes put into Place to Assure /Deficit Practices do not recur are as Follows:** Protected Health Information and the HIPAA Privacy Rule provide to facility staff along with the interdisciplinary on 09/21/16. Consultant are now utilizing audit sheets and compliance forms for monitoring staff compliance with the HIPPA privacy rule. IV. **Corrective Actions will be monitored to Ensure Compliance by**: The Administrator will observe compliance via daily walking rounds and review daily with audit forms then weekly x 4 weeks, then monthly x 5 months. Walking rounds will include observation to ensure that doors and curtains are in place and in functioning condition. Deficient areas will be addressed immediately. The Administrator will report findings to the QA committee monthly who will then decide on continued need and/or frequency of monitoring after 6 months.	

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	unintentionally used or disclosed in a manner that would violate the HIPAA Privacy Rule or any other federal or state regulation governing confidentiality and privacy of health information...Active Medical Records shall not be left unattended on the nurses' station desk or other areas where residents, visitors, an unauthorized individuals could easily view the records...." 2. During an observation, on 8/24/16 at 9:58 a.m., there was no bathroom door observed in Resident #54's room. An interview was conducted with Resident #54 on 8/24/16 at 10:00 a.m. He indicated there has been no bathroom door since he had resided in the facility and he has a roommate. The clinical record for Resident #54 was reviewed on 8/30/16 at 2:45 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure. Resident #54 was admitted to the facility on 7/21/16. The Admission MDS (Minimum Data Set) assessment, completed on 7/28/16, indicated a BIMS (Brief Interview for Mental Status Score) of 8/15 indicating			

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	moderate cognitive impairment. An environmental tour was conducted with the Maintenance Director on 8/31/16 at 11:00 a.m. Resident #54's room was observed without a bathroom door. The Maintenance Director indicated corporate personnel comes in once or twice a month and conducts an audit of the facility that will list what all needs to be followed up with in regards to the resident environment. The corporate personnel then prints off that list and will give it to him to follow up with. A document titled "[Facility Name] Room Rounds Report]", dated 6/1/16, was provided by the Regional Director of Clinical Operations on 8/31/16 at 1:30 p.m. The document indicated the following, "...Rm [Room]...[Resident #54's room number]...no bathroom door...." An interview was conducted with the Maintenance Director on 8/31/16 at 11:40 a.m. He indicated he was unaware of the missing door and that a door should be placed due to privacy concerns with there being two residents residing in that room.			

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	A policy titled "Promoting/Maintaining Resident Dignity", no revision date, was provided by the Vice President of Operations on 8/31/16 at 4:03 p.m. The policy indicated the following, "...Compliance Guidelines:...12. Maintain resident privacy...." 3.1-3(o) 3.1-3(p)(1) 3.1-3(p)(4)			
F 0225 SS=L Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property			

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	are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to protect residents during an abuse investigation, report allegations timely, identify allegations as potential abuse, and investigate allegations thoroughly, after allegations of abuse were reported to them. This had the potential to affect all 44 residents in the facility. The immediate jeopardy began on 8/23/16 when the facility was notified about allegations of abuse and failed to protect residents during an abuse investigation, report allegations timely, identify allegations as potential abuse, and investigate allegations thoroughly.	F 0225	F225 The facility does protect residents during an abuse investigation, report allegations timely, identify allegations as potential abuse, and investigate allegations thoroughly when allegations of abuse are reported. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The R DO reviewed the abuse allegations investigations for resident #26, #35 a and b, and #28 and oversaw them, with the Administrator, until each one completed. Any identified, suspected perpetrator(s) were suspended pending completion of investigation. The Facility Abuse	09/30/2016

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	The Administrator, Regional Director of Operations, and Regional Director of Clinical Operations were notified of the immediate jeopardy at 5:55 p.m., on 8/25/16. The immediate jeopardy was removed on 8/29/16, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The clinical record for Resident #26 was reviewed on 8/26/16 at 3:54 p.m. The diagnoses included, but were not limited to: bipolar disorder, post-traumatic stress disorder, anxiety, and hemiplegia. The record indicated Resident #26 was admitted to facility on 9/21/15. A Quarterly MDS (Minimum Data Set) Assessment, completed on 7/12/16, showed a BIMS (Brief Interview for Mental Status) score of 13 of 15 indicating Resident #26 was cognitively intact. An interview conducted with Resident #26, on 8/23/16 at 12:06 p.m., indicated at approximately 3:00 a.m., on 8/23/16, a "heavy set CNA [Certified Nursing Assistant], who works third shift, wears her hair in a bun, and is colored," refused to reposition him the way he insisted her		and Neglect Policy and Procedure was reviewed and found to be appropriate. The R DO in-serviced the Administrator on the Abuse policy on 8/25/16 and included definitions of abuse and review of all seven required components (screening,training, prevention, identification, investigation, protection and reporting/response). All current employee files were reviewed by the BOM/Designee on 8/26/16 to ensure all screenings were completed. Any deficient area was addressed immediately. SSD/Designee reviewed the facility Grievance procedure and facility compliance hotline with all residents and/or their responsible contacts. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** This alleged deficient practice had the potential to affect all residents. All residents were interviewed by SSD/R DO/Administrator/Designee on 8/26/16 to determine if there were any other concerns with other residents or staff. Any potential allegation of abuse was investigated immediately and any identified perpetrator(s) were suspending pending completion of the investigation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not**	

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	to do so. She proceeded to tell Resident #26 that she was not answering his call light anymore for the rest of the shift. Resident #26 stated the CNA stood in the doorway of his room with a pen pointed at him and stated the following, " I'm tired of running around for you [Resident #26]." He then stated the CNA was standing in the doorway outside of his room conversing with another CNA, and stated the following to the other CNA, " He [Resident #26] wants me to run in and out of the bedroom every five minutes and he is pulling the alarm." Resident #26 then stated the CNA called him a "m----------," while conversing with another CNA in the doorway of his room. Resident #26 had not told anyone about the language expressed by the CNA. He stated he was terrified of his health and well-being because of the CNA's actions. On 8/23/16 at 12:30 p.m., the Administrator was made aware of the verbal allegation of abuse expressed by Resident #26, along with 3 other allegations from other residents. The Administrator indicated he was not aware of the alleged verbal abuse from a CNA to Resident #26. On 8/25/16 at 5:30 p.m., the Administrator provided documentation in regards to the investigation regarding		**recur?** All Facility staff members were in-serviced by Administrator/R DO/Designee on the Abuse policy. The in-service was initiated on 8/25/16 and no employee returned to duty until in-service received and acknowledged understanding. In addition, the abuse policy will be in -serviced to all new hires, annually and as deemed necessary by the Administrator R DO. The SSD/Designee will meet with affected residents a minimum of weekly x 1 month to ensure psycho social needs are being met. Meetings will continue based on resident response and needs. The Plan of Care will be modified based on individual resident needs. The R DO will review all abuse allegations and investigations to ensure proper protection of residents and timely reporting. Any identified deficient practice will be addressed immediately. This will be on-going. The facility resident council host will review the grievance procedure and compliance hotline monthly with residents, during each resident council meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?** The R DO and Administrator will hold a daily conversation x 1 mo, then weekly x 4 weeks and monthly thereafter	

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	verbal abuse from staff to Resident #26. He provided seven documents indicating the following, "8/23/206 [sic]...Interviewed Staff Allegation of Abuse Residents...1. Are you aware of any incidents (allegations) of abuse since 8/12/2016?...2. Has any Residents notified you or said anything regrading [sic] an altercation with staff?...3. Has any residents spoken or said anything with resident to resident altercations?...4. Who do report [sic] allegation to immediately?...." The documents were signed by various staff members and dated for 8/23/16. The Administrator indicated the documents were in regards to the investigation of verbal abuse by staff towards Resident #26. An interview conducted with the Administrator, on 8/26/16 at 9:50 a.m., indicated the night shift CNA was suspended pending investigation immediately on 8/23/16 and he identified the night shift CNA as CNA #7. A document titled "Employee Corrective Action" was provided by the Administrator on 8/26/16 at 9:50 a.m. The document stated the following, "...Facility Name [name of facility]...Date of Corrective Action: 8/23/16 ...Employee Name [name of CNA #7]...Reason for warning (detail who,		if compliance has been achieved/sustained at 100%, to discuss any potential assumptions/allegations of abuse to ensure no complaint or concern is dismissed without a thorough investigation and protection of the residents. The SSD/Designee will interview 5 residents weekly x 1mo, then 5 residents every 2 weeks x 1 month and then 5 residents monthly x 4more months, to determine if there are any concerns with other residents or staff. Any concerns will be reported to the Administrator immediately and any identified suspect/perpetrator(s) will be suspended immediately pending a complete investigation. The Administrator will review minutes from each resident council meeting to ensure the grievance policy and compliance hotline were reviewed. The R DO, Administrator and SSD/Designee will report their findings monthly to the facility Q AA team who will determine the need/frequency of further monitoring after 6 months and/or if changes in monitoring need to occur based on results.	

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	what, when, where, and how): staff person is receiving this suspension pending out come [sic] of the investigation. If the investigation prove negative [sic] then she can be reinstated...Other Corrective Actions to be Taken: Removed from schedule pending out come [sic] of the investigation...." Document signed by the Administrator and dated for 8/23/16. An interview was conducted with QMA (Qualified Medication Aide) #1, on 8/26/16 at 2:00 p.m. She commented that CNA #7 worked the nights of 8/24/16 and 8/25/16. An interview was conducted with Resident #26, on 8/26/16 at 2:18 p.m. He indicated CNA #7 worked the night of 8/25/16 to 8/26/16 in the morning. He stated CNA #7 came into his room once during the night shift to provide care. A document titled "Employee Timecard Report" was provided by the Administrator on 8/26/16 at 2:23 p.m. The document stated CNA #7 worked on the following days: 8/24/16 from 10:55 p.m. to 6:06 a.m. 8/26/16 from 12:10 a.m. to 6:10 a.m. An interview was conducted with the Administrator, on 8/26/16 at 10:35 a.m. He indicated he had not completed a statement from CNA #7 in regards to the			

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	abuse allegation involving Resident #26. An interview was conducted with the Administrator, on 8/26/16 at 2:28 p.m. He indicated the investigation regarding verbal abuse involving Resident #26 was not completed at this time, due to having a few more interviews to do. He stated CNA #7 worked last night into the morning. An interview conducted with the Regional Director of Operations (RDO), on 8/26/16 at 2:30 p.m., indicated the investigation was completed, because CNA #7 was back to work. An interview conducted with the Administrator, on 8/26/16 at 2:32 p.m., indicated the abuse investigation regarding Resident #26 and CNA #7 was completed. He indicated he obtained a verbal statement from CNA #7, but had not obtained a written statement from CNA #7. He stated CNA #7 was only suspended for the day of 8/23/16. An interview conducted with the Administrator on 8/26/16 at 2:45 p.m., indicated he was wrapping up the investigation and attempting to locate the interviews obtained from staff members in regards to the staff to Resident #26 abuse investigation. On 8/26/16 at 3:20 p.m., an interview was conducted with the Administrator.			

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	He stated, to determine the outcome of the investigation, he did the following, "looked at the hour by hour timeline for when staff went into Resident #26's room, delegated Social Services to interview ten other residents and Resident #26's roommate, delegated RDO to interview Resident #26 in regards to abuse allegation directed towards CNA #7, and obtained a verbal statement from CNA #7 and wrote it down on paper." He indicated CNA #7 received abuse in-service training prior to coming back to work. He stated CNA #7 was suspended as disciplinary action on 8/23/16, pending the outcome of the investigation. The Administrator then stated CNA #7 came back to work the night of 8/24/16. A telephone interview was conducted with CNA #7 on 8/26/16 at 3:33 p.m. She stated the facility notified her via phone the morning of 8/26/16 to inform her she was suspended, but did not specify the reason why she was suspended. She worked the previous night until 6:00 a.m. on 8/26/16. She also worked Monday and Wednesday night shifts this week and indicated the RDO (Regional Director of Operations) was present during the early morning hours of 8/26/16, and she was in-serviced on			

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	abuse by the RDO. CNA #7 stated she was never suspended prior to 8/26/16, and had not given a verbal or written statement to any staff member regarding any resident. As of 8/26/16 at 4:30 p.m., the RDO indicated facility staff were still trying to locate the finished investigative file for staff to resident abuse, in regards to Resident #26. The following information was still needed at this time: Resident #26's statement, CNA #7's statement, Statement from Resident #26's roommate, Other residents statements, & Abuse in-service training for CNA #7. A document was provided by the Administrator on 8/26/16 at 9:50 a.m., indicating the following, "[name of facility]...Reported to ISDH [Indiana State Department of Health] by: [name of Administrator]...Incident Date: 8/23/2016 ...Incident Time: 03:30 AM...Resident(s) Involved....[Name of Resident #26]...Brief Description of Incident...Description added - 8/23/2016 Resident stated staff person was arrogant and rude. Stated person did not respond to his request. Stated the person is the biggest person with her hair in a bun. Stated she was intimidating me scolding			

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	me. Stated staff was in the hallway laughing ...Immediate Action Taken ...INCIDENT REPORTED TO ISDPH [sic] STAFF PERSON ON MIDNIGHT SHIFT SUSPENDED. INVESTIGATION STARTED. STAFF NARRATIVE RECEIVED. Resident documented time line reviewed. Care Plan reviewed. Staff review of resident rights and allegation of abuse inserviced [sic]...." 2. a) The clinical record for Resident #35 was reviewed on 8/23/16 at 2:30 p.m. The diagnoses for Resident #35 included, but were not limited to: bipolar disorder, depression, depressive disorder, and personality disorder. Resident #35's admission date was 7/19/16. An Annual MDS (minimum data set) assessment with a BIMS (brief interview for mental status) for Resident #35 indicated a score 13 of 15 indicating Resident #35 was cognitively intact. During an interview with Resident #35 on 8/23/16 at 11:36 a.m., she reported she had been verbally abused by day shift Certified Nursing Assistant (CNA) #3 on 8/22/16. Resident #35 stated she soiled her linens on her bed. She indicated CNA #3 provided incontinent care and changed her linens, but CNA #3 refused to remove			

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	the soiled linens from her room. Resident #35 stated as CNA #3 was leaving her room, she called Resident #35 a "..fat b----". Resident #35 indicated she reported the incident to Qualified Medical Assistant (QMA) #5. She stated she was told by QMA #5 that CNA #3 was written up and would no longer be allowed to take care of her. Resident #35 indicated she had not been cared for by CNA #3 or seen her since the incident. On 8/23/16 at 12:36 p.m., the Administrator was informed of the above allegation made by Resident #35 against CNA #3. The Administrator stated he would need to check whether the allegation was reported, and if there was an investigation on it. An interview was conducted with the Administrator on 8/24/16 at 11:33 a.m. to follow up on Resident #35's allegation. He reported he did not have any reports from the facility's staff regarding a CNA verbally abusing Resident #35. The Administrator indicated this was a type of allegation that needed to be investigated, when reported. At this time, the Administrator stated an investigation was being conducted into this abuse allegation. An interview was conducted with the Administrator on 8/25/16 at 4:50 p.m. He reported the verbal allegation related to Resident #35 and CNA #3 was almost			

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	completed. The Administrator indicated he was still needing a statement from CNA #3. An interview was conducted with the the Regional Director of Operations (RDO) on 8/26/16 at 10:01 a.m. She stated she could not locate the reportable in the Indiana State Department of Health reporting system. An interview was conducted with the Administrator on 8/26/16 at 10:15 a.m. He stated he had entered the abuse allegation on 8/24/16, but it must not have saved in the reporting system. 2. b) During an interview with Resident #35 on 8/23/16 at 11:36 a.m., Resident #35 reported on the evening of 8/22/16, she was hit in the face with a stuffed animal by Resident #45 while she was using the telephone at the nurse's station. She reported the evening nurse and other staff members were present during the incident, but she could not recall the staff members' names. Resident #35 stated after she was hit, a staff member took Resident #45 down the hall toward the vending machines. At that same time, another staff member gave her a cordless phone, and was told to go to her room to make her call. Resident #35 reported she asked the staff person why she was being told to go to her room, when she was not			

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	the one to hit anyone. She states she was told by the facility staff member they needed to separate both of them. On 8/23/16 at 12:36 p.m., the Administrator was informed of the above allegation made by Resident #35 against Resident #45. The Administrator stated he would need to check whether the allegation was reported, and if there was an investigation on it. An interview was conducted with the Administrator on 8/24/16 at 11:33 a.m., to follow up on the above allegation. He indicated he did not have any reports from the facility staff regarding Resident #35 and Resident #45 had a physical altercation. The Administrator indicated this type of allegation needed investigated, when reported. At this time, he indicated an investigation was being conducted into this abuse allegation. An investigative report was provided by the Administrator on 8/25/16 at 4:50 p.m., regarding Resident #35 and Resident #45's physical altercation. He indicated at that time, the investigation was completed. An interview was conducted with the Administrator on 8/25/16 at 3:23 p.m. He stated the investigation for Resident #35's allegation and several other allegations "all ran together". He indicated he only had one investigation summary, and provided it at this time. The information			

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	pertaining to Resident #35's allegation included in the investigation, was a paragraph statement regarding the staff nurse per Resident #35's statement that was present during the incident. This statement did not include a date or time and was a written general statement regarding the staff person was not employed with the facility at the time of the occurrence. It included an interview with a resident's statement. The statement included only a first name and no date or time. The summary included an interview with QMA #5, but did not include a date or time. It included a question "Do you have knowledge of an incident with (name of resident) Resident #35, and ..." This question had no response or whom had been asked the question. It also included an "interview with nurse on the second shift unit" there was no name given of the nurse interviewed or date. The remaining investigation in the file included the following: 8/24/16 incident report to Indiana State Department Health, an undated statement from Resident #35, and 7 interviews of staff members that were asked the following: "...1. Are you aware of any incidents (allegations) of abuse since 8/12/16? ..2. Has any Residents notified you or said anything regarding an altercation with staff? ..3. Has any residents spoken or said anything with resident to resident			

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	altercations? ..4. Who do (sic) report allegation to immediately?.." A staff daily schedule dated 8/22/16, was provided by the RDO on 8/25/16 at 5:45 p.m. The investigative file included one resident interview, other than Resident #35. This interview with the resident indicated there was no altercation that occurred with Resident #35 and Resident #45. 3. The clinical record for Resident #28 was reviewed on 8/23/16 at 11:00 a.m. The diagnoses for Resident #28 included, but were not limited to, depression. The 8/2/16 Quarterly MDS (minimum data set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An interview was conducted with Resident #28 on 8/23/16 at 11:19 a.m. She reported she saw another resident in the facility being abused. She reported an employee, named (female name) told a resident, "I don't have time for your s---." Resident #28 stated this occurred "last week" in the "back area" of the facility. She stated she was in bed at the time, but her door was open. She indicated she did			

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	not tell staff because, "nothing would be done." The Administrator of the facility was informed of Resident #28's above allegation of an employee cursing at a resident, on 8/23/16 at 12:27 p.m., along with 3 other allegations from other residents. An interview was conducted with the Administrator on 8/25/16 at 9:33 a.m., to follow up on Resident #28's allegation. He informed there was no employee in the facility or any agency employee named (same female name given by Resident #28). He indicated he tried to speak with Resident #28 about her allegation, but did not ask her about her statement regarding an employee cursing at a resident. He indicated, "When I got ready to ask her about it, she said I need to get her t.v. fixed. I asked her if there was anything else she needed to talk to me about, and she said no, so I left out the room. My plan now, is to go back in there each day. I don't consider what (name of Resident #28) said as an allegation of abuse, because I don't have an actual staff person indicated." He stated he would speak with Resident #28 again, and take the Activity Director in there with him.			

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	The 8/25/16, 10:30 a.m. Incident Report indicated, "Brief Description of Incident: Description added -- 8/25/16 ISDPH (sic) conducting annual survey. Surveyor requested administrator to interview resident 20-1 (Resident #28). Administrator went to interview resident. Resident did acknowledge any abuse to administrator verbally, physically sexually or any other type of abuse. Resident did not state any fear or other conditioner (sic) by the interview." This incident did not indicate receiving information that an aide cursed at a resident. This report was submitted to the ISDH on 8/25/16 by the Administrator, 2 days after Resident #28's allegation was reported to the facility. An interview was conducted with the Administrator on 8/25/16 at 5:59 p.m. He stated he spoke to Resident #28 on 8/23/16, but her only concern was with her t.v., and she didn't say anything about abuse. He indicated he did not attempt to reinterview her on 8/24/16, because he was following up on other things. He reported he did not designate another staff member to do the investigation. An interview was conducted with the SSD (Social Services Director) on 8/25/16 at 9:56 a.m. She indicated she,			

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	the Administrator, and Activity Director just finished talking to Resident #28. The SSD reported Resident #28 informed them she had not witnessed any abuse to any other resident. The SSD stated Resident #28 used to have a care plan for making false allegations against staff, but she discontinued it at her last care plan meeting a few weeks ago, because Resident #28 was no longer doing that. The SSD informed there was a CNA (Certified Nursing Assistant) named (female name sounding similar to name given by Resident #28), and perhaps, that was who Resident #28 was referencing. An interview was conducted with Nurse Practitioner (NP) #8 on 8/26/16 at 9:23 a.m. She indicated Resident #28 had a history of making false allegations, but she hadn't done that "for a long time, at least 2 years." An interview was conducted with the Administrator on 8/25/16 at 10:43 a.m. He indicated Resident #28 informed him she never heard any staff person abusing a resident. He stated he was getting the impression from Resident #28 that she didn't want to get anyone in trouble, because she was unsure if it was a resident or staff. An interview was conducted with			

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	Resident #28 on 8/29/16 at 9:21 a.m. She indicated the information regarding an aide cursing at another resident was heresay from another staff member, but she couldn't remember who. She stated she did not see or hear an aide curse at another resident. She indicated the Administrator, Activity Director, and SSD came in and spoke with her about the allegation the previous week, a day or 2 after she reported it. She stated she felt uncomfortable and intimidated talking to staff about allegations of abuse, because she felt like she might be retaliated against. She stated it seemed to her like the facility would believe a staff member over a resident. An interview was conducted with the Administrator on 8/25/16 at 3:23 p.m. He stated the investigation for Resident #28's allegation and several other allegations "all ran together", so he only had one investigation, and provided it at this time. The information pertaining to Resident #28's allegation, included in the investigation, were the 8/25/16, 10:30 a.m. incident report, an 8/25/16 interview with Resident #28, an interview with CNA #5, an 8/25/16 summary of an interview with Resident #28 written by the Activity Director, and an 8/25/16 summary of an interview with Resident #28 written by the SSD. The			

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	Administrator indicated the investigation was complete, except for a summary of findings, and the abuse was unsubstantiated. The Abuse & Neglect policy was provided by the Administrator on 8/24/16 at 2:41 p.m. It indicated, "Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." It indicated, "Identification...The staff will identify events, occurrences, patterns, and trends that may constitute abuse and to determine the direction of the investigation." It indicated, "Investigation...The facility will designate someone to investigate the allegations and report the results of the investigation to the administrator or his/her designated representative and to other officials in accordance with State law...It indicated, "Protection...The facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified, that person will be suspended pending investigation in accordance with the progressive discipline policy." It indicated, "Investigation...Alleged			

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	violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law." 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0226 SS=L Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview, and record review, the facility failed to implement 4 out of 7 components of their abuse policy after allegations of abuse were reported to them. This had the potential to affect all 44 residents in the facility. The immediate jeopardy began on 8/23/16 when the facility failed to ensure 4 out of 7 components of their abuse policy were implemented. The Administrator, Regional Director of Operations, and Regional Director of Clinical Operations were notified of the immediate jeopardy at 5:55 p.m., on 8/25/16. The immediate jeopardy was	F 0226	F226 The facility does develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The RDO reviewed the abuse allegations investigations for resident #26, #35 a and b, and #28 and oversaw them, with the Administrator,until each one completed. Any identified, suspected perpetrator(s) were suspended pending completion of investigation. The Facility Abuse	09/30/2016

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	removed on 8/29/16, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The clinical record for Resident #26 was reviewed on 8/26/16 at 3:54 p.m. The diagnoses included, but were not limited to: bipolar disorder, post-traumatic stress disorder, anxiety, and hemiplegia. The record stated Resident #26 was admitted to facility on 9/21/15. A Quarterly MDS (Minimum Data Set) Assessment, completed on 7/12/16, indicated a BIMS (Brief Interview for Mental Status) score of 13 of 15 indicating Resident #26 was cognitively intact. An interview conducted with Resident #26, on 8/23/16 at 12:06 p.m., indicated at approximately 3:00 a.m., on 8/23/16, a "heavy set CNA [Certified Nursing Assistant], who works third shift, wears her hair in a bun, and is colored," refused to reposition him the way he insisted her to do so. She proceeded to tell Resident #26 that she was not answering his call light anymore for the rest of the shift.		and Neglect Policy and Procedure was reviewed and found to be appropriate. The RDO in-serviced the Administrator on the Abuse policyon 8/25/16 and included definitions of abuse and review of all seven required components (screening, training, prevention, identification, investigation,protection and reporting/response). All current employee files were reviewed by the BOM/Designee on 8/26/16 to ensure all screenings were completed. Any deficient area was addressed immediately. SSD/Designee reviewed the facility Grievance procedure and facility compliance hotline with all residents and/or their responsible contacts. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** This alleged deficient practice had the potential to affect all residents. All residents were interviewed by SSD/RDO/Administrator/Designe e on 8/26/16 to determine if there were any other concerns with other residents or staff. Any potential allegation of abuse was investigated immediately and any identified perpetrator(s) were suspending pending completion of the investigation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not**	

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	Resident #26 then stated the CNA stood in the doorway of his room with a pen pointed at him and stated the following, " I'm tired of running around for you [Resident #26]." He reported the CNA was standing in the doorway outside of his room conversing with another CNA, and stated the following to the other CNA, "He [Resident #26] wants me to run in and out of the bedroom every five minutes and he is pulling the alarm." Resident #26 then reported the CNA called him a "m----------," while conversing with another CNA in the doorway of his room. Resident #26 had not told anyone about the language expressed by the CNA. He then stated he was terrified of his health and well-being because of the CNA's actions. On 8/23/16 at 12:30 p.m., the Administrator was made aware of the verbal allegation of abuse expressed by Resident #26, along with 3 other allegations from other residents. The Administrator indicated he was not aware of the alleged verbal abuse from a CNA to Resident #26. An interview conducted with the Administrator, on 8/26/16 at 9:50 a.m., indicated the night shift CNA was suspended pending investigation immediately on 8/23/16. He further		**recur?** All Facility staff members were in-serviced by Administrator/RDO/Designee on the Abuse policy. The in-service was initiated on 8/25/16 and no employee returned to duty until in-service received and acknowledged understanding. In addition, the abuse policy will be in-serviced to all new hires, annually and as deemed necessary by th e Administrator or RDO. The SSD/Designee will meet with affected residents a minimum of weekly x 1 month to ensure psychosocial needs are being met. Meetings will continue based on resident response and needs. The Plan of Care will be modified based on individual resident needs. The RDO will review all abuse allegations and investigations to ensure proper protection of residents and timely reporting. Any identified deficient practice will be addressed immediately. This will be on-going. The facility resident council host will review the grievance procedure and compliance hotline monthly with residents, during each resident council meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?** The RDO and Administrator will hold a daily conversation x 1 mo, then weekly x 4 weeks and monthly thereafter	

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	indicated the night shift CNA was identified as CNA #7. A document titled "Employee Corrective Action" was provided by the Administrator on 8/26/16 at 9:50 a.m. The document stated the following, "...Facility Name [name of facility]...Date of Corrective Action: 8/23/16 ...Employee Name [name of CNA #7]...Reason for warning (detail who, what, when, where, and how): staff person is receiving this suspension pending out come [sic] of the investigation. If the investigation prove negative [sic] then she can be reinstated...Other Corrective Actions to be Taken: Removed from schedule pending out come [sic] of the investigation...." Document signed by the Administrator and dated for 8/23/16. An interview was conducted with QMA (Qualified Medication Aide) #1, on 8/26/16 at 2:00 p.m. She stated CNA #7 worked the nights of 8/24/16 and 8/25/16. An interview was conducted with Resident #26, on 8/26/16 at 2:18 p.m. He stated CNA #7 worked the night of 8/25/16 to 8/26/16 in the morning. He then stated CNA #7 came into his room once during the night shift to provide		if compliance has been achieved/sustained at 100%, to discuss any potential assumptions/allegations of abuse to ensure no complaint or concern is dismissed without a thorough investigation and protection of the residents. The SSD/Designee will interview 5 resident's weekly x 1mo, then 5 residents every 2 weeks x 1 month and then 5 residents monthly x 4more months, to determine if there are any concerns with other residents or staff. Any concerns will be reported to the Administrator immediately and any identified suspect/perpetrator(s) will be suspended immediately pending a complete investigation. The Administrator will review minutes from each resident council meeting to ensure the grievance policy and compliance hotline were reviewed. The R DO, Administrator and SSD/Designee will report their findings monthly to the facility Q AA team who will determine the need/frequency of further monitoring after 6 months and/or if changes in monitoring need to occur based on results	

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	care. A document titled "Employee Timecard Report" was provided by the Administrator on 8/26/16 at 2:23 p.m. The document indicated CNA #7 worked on the following days: 8/24/16 from 10:55 p.m. to 6:06 a.m. 8/26/16 from 12:10 a.m. to 6:10 a.m. A policy titled "Abuse & Neglect" was provided by the Administrator on 8/24/16 at 2:41 p.m. The policy indicated the following, "...Protection...The facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified, that person will be suspended pending investigation...." An interview was conducted with the Administrator, on 8/26/16 at 10:35 a.m. He indicated he had not completed a statement from CNA #7 in regards to the abuse allegation involving Resident #26. An interview was conducted with the Administrator, on 8/26/16 at 2:28 p.m. He indicated the investigation regarding verbal abuse involving Resident #26 was not completed at this time, due to having a few more interviews to do. He further indicated CNA #7 worked last night into			

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	the morning. An interview conducted with the Regional Director of Operations (RDO), on 8/26/16 at 2:30 p.m., indicated the investigation was completed, because CNA #7 was back to work. An interview conducted with the Administrator, on 8/26/16 at 2:32 p.m., indicated the abuse investigation regarding Resident #26 and CNA #7 was completed. He further indicated he obtained a verbal statement from CNA #7, but had not obtained a written statement from CNA #7. He stated CNA #7 was only suspended for the day of 8/23/16. An interview conducted with the Administrator on 8/26/16 at 2:45 p.m., indicated he was wrapping up the investigation and attempting to locate the interviews obtained from staff members in regards to the staff to Resident #26 abuse investigation. On 8/26/16 at 3:20 p.m., an interview was conducted with the Administrator. He stated, to determine the outcome of the investigation, he did the following, "looked at the hour by hour timeline for when staff went into Resident #26's room, delegated Social Services to			

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	interview ten other residents and Resident #26's roommate, delegated RDO to interview Resident #26 in regards to abuse allegation directed towards CNA #7, and he obtained a verbal statement from CNA #7 and wrote it down on paper." He then stated CNA #7 received abuse in-service training prior to coming back to work. He indicated CNA #7 was suspended as disciplinary action on 8/23/16, pending the outcome of the investigation. The Administrator stated CNA #7 came back to work the night of 8/24/16. A policy titled "Abuse & Neglect", revised 9/1/14, was provided by the Administrator on 8/24/16 at 2:41 p.m. The policy indicated the following, "...Investigation...The facility will designate someone to investigate the allegations and report the results of the investigation to the administrator or his/her designated representative and to other officials in accordance with State law...The investigator will review relevant documentation, including relevant parts of the medical records, and interview witnesses...." A telephone interview was conducted with CNA #7 on 8/26/16 at 3:33 p.m. She stated the facility notified her via phone the morning of 8/26/16 to inform her she			

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	was suspended, but did not specify the reason why she was suspended. She indicated she worked the previous night until 6:00 a.m. on 8/26/16. She indicated she worked Monday and Wednesday night shifts this week. She stated the RDO was present, when she was working at the facility the early morning hours of 8/26/16, and was in-serviced on abuse by the RDO. CNA #7 then stated she was never suspended prior to 8/26/16, and had not given a verbal or written statement to any staff member regarding any resident. As of 8/26/16 at 4:30 p.m., the RDO indicated facility staff were still trying to locate the finished investigative file for staff to resident abuse, in regards to Resident #26. The following information was still needed at this time: Resident #26's statement, CNA #7's statement, Statement from Resident #26's roommate, Other residents statements, & Abuse in-service training for CNA #7. A document was provided by the Administrator on 8/26/16 at 9:50 a.m., stating the following, "[name of facility]...Reported to ISDH [Indiana State Department of Health] by: [name of			

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	Administrator]...Incident Date: 8/23/2016 ...Incident Time: 03:30 AM...Resident(s) Involved....[Name of Resident #26]...Brief Description of Incident...Description added - 8/23/2016 Resident stated staff person was arrogant and rude. Stated person did not respond to his request. Stated the person is the biggest person with her hair in a bun. Stated she was intimidating me scolding me. Stated staff was in the hallway laughing ...Immediate Action Taken ...INCIDENT REPORTED TO ISDPH [sic] STAFF PERSON ON MIDNIGHT SHIFT SUSPENDED. INVESTIGATION STARTED. STAFF NARRATIVE RECEIVED. Resident documented time line reviewed. Care Plan reviewed. Staff review of resident rights and allegation of abuse inserviced [sic]...." A document titled "Abuse and Neglect Policy", revised on 9/01/14, was provided by the Administrator on 8/24/16 at 2:41 p.m. The policy indicated the following, "Policy ...Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated ...Investigation ...The investigator will review relevant documentation, including relevant parts of the medical records, and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview witnesses. The facility will document the findings of the investigation on an investigation form developed by the facility unless a different form is required by state law. The documentation will include the identity of the staff member responsible for the initial reporting, investigation of alleged violations, and reporting of results to the proper authorities ...Protection ...The facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified, that person will be suspended pending investigation in accordance with the progressive discipline policy. If the alleged violation is substantiated, appropriate corrective action will be taken...."2. a) The clinical record for Resident #35 was reviewed on 8/23/16 at 2:30 p.m. The diagnoses for Resident #35 included, but were not limited to: bipolar disorder, depression, depressive disorder, and personality disorder. Resident #35's admission date was 7/19/16. An Annual MDS (minimum data set) assessment with a BIMS (brief interview for mental status) for Resident #35 indicated a score 13 of 15 indicating Resident #35 was cognitively intact.			

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	155721	A. BUILDING 00 B. WING	08/31/2016

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	During an interview with Resident #35 on 8/23/16 at 11:36 a.m., she indicated she had been verbally abused by day shift Certified Nursing Assistant (CNA) #3 on 8/22/16. Resident #35 stated she soiled her linens on her bed. She reported CNA #3 provided incontinent care and changed her linens, but CNA #3 refused to remove the soiled linens from her room. Resident #35 stated as CNA #3 was leaving her room, she called Resident #35 a "..fat b----". Resident #35 stated she reported the incident to Qualified Medical Assistant (QMA) #5. She indicated she was told by QMA #5 that CNA #3 was written up and would no longer be allowed to take care of her. Resident #35 indicated she had not been cared for by CNA #3 or seen her since the incident. On 8/23/16 at 12:36 p.m., the Administrator was informed of the above allegation made by Resident #35 against CNA #3. The Administrator indicated he would need to check whether the allegation was reported, and if there was an investigation on it. An interview was conducted with the Administrator on 8/24/16 at 11:33 a.m. to follow up on Resident #35's allegation. He indicated he did not have any reports from the facility's staff regarding a CNA verbally abusing Resident #35. The			

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	Administrator indicated this was a type of allegation that neeed to be investigated, when reported. At this time, he indicated an investigation was being conducted into this abuse allegation. An interview was conducted with the Administrator on 8/25/16 at 4:50 p.m. He reported the verbal allegation related to Resident #35 and CNA #3 was almost completed. The Administrator stated he was still needing a statement from CNA #3. An interview was conducted with the the Regional Director of Operations (RDO) on 8/26/16 at 10:01 a.m. She indicated she could not locate the reportable in the Indiana State Department of Health reporting system. An interview was conducted with the Administrator on 8/26/16 at 10:15 a.m. He reported he had entered the abuse allegation on 8/24/16, but it must not have saved in the reporting system. 2. b) During an interview with Resident #35 on 8/23/16 at 11:36 a.m., Resident #35 stated on the evening of 8/22/16, she was hit in the face by Resident #45 with a stuffed animal. Resident #35 reported she was using the telephone at the nurse's station when Resident #45 approached			

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	her at that time and hit her in the face with a stuffed animal. She indicated the evening nurse and other staff members were present during the incident, but she could not recall the staff members' names. Resident #35 stated after she was hit, a staff member took Resident #45 down the hall toward the vending machines. At that same time, another staff member gave her a cordless phone, and was told to go to her room to make her call. Resident #35 indicated she asked the staff person why she was being told to go to her room, when she was not the one to hit anyone. She indicated she was told by the facility staff member they needed to separate both of them. On 8/23/16 at 12:36 p.m., the Administrator was informed of the above allegation made by Resident #35 against Resident #45. The Administrator indicated he would need to check whether the allegation was reported, and if there was an investigation on it. An interview was conducted with the Administrator on 8/24/16 at 11:33 a.m., to follow up on the above allegation. He indicated he did not have any reports from the facility staff regarding Resident #35 and Resident #45 had a physical altercation. The Administrator indicated this type of allegation needed			

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	investigated, when reported. At this time, he indicated an investigation was being conducted into this abuse allegation. An investigative report was provided by the Administrator on 8/25/16 at 4:50 p.m., regarding Resident #35 and Resident #45's physical altercation. He indicated at that time, the investigation was completed. An interview was conducted with the Administrator on 8/25/16 at 3:23 p.m. He indicated the investigation for Resident #35's allegation and several other allegations "all ran together". He stated he only had one investigation summary, and provided it at this time. The information pertaining to Resident #35's allegation included in the investigation, a paragraph statement regarding the staff nurse per Resident #35's statement was not employed with the facility at the time of the occurrence. It included an interview with a resident's statement. The statement included only a first name and no date or time. The summary included an interview with QMA #5, but did not include a date or time. It included a question "Do you have knowledge of an incident with (name of resident) Resident #35, and ..." This question had no response or whom had been asked the question. It also included an "interview			

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	with nurse on the second shift unit" there was no name given of the nurse interviewed or date. The remaining investigation in the file included the following: 8/24/16 incident report to Indiana State Department Health, an undated statement from Resident #35, and 7 interviews of staff members that were asked the following: "...1. Are you aware of any incidents (allegations) of abuse since 8/12/16? ..2. Has any Residents notified you or said anything regarding an altercation with staff? ..3. Has any residents spoken or said anything with resident to resident altercations? ..4. Who do (sic) report allegation to immediately?.." A staff daily schedule dated 8/22/16, was provided by the RDO on 8/25/16 at 5:45 p.m. The investigative file included one resident interview, other than Resident #35. This interview with the resident indicated there was no altercation that occurred with Resident #35 and Resident #45. The abuse policy dated 9/1/14, indicated "...Policy. Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to			

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	State and Federal Law and investigated...How staff should report their knowledge related to allegations without fear or reprisal...Investigation...The facility will designate someone to investigate the allegations and report the results of the investigation to the administrator or his/her designated representative an to other officials in accordance with State law..." 3. The clinical record for Resident #28 was reviewed on 8/23/16 at 11:00 a.m. The diagnoses for Resident #28 included, but were not limited to, depression. The 8/2/16 Quarterly MDS (minimum data set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An interview was conducted with Resident #28 on 8/23/16 at 11:19 a.m. She reported she saw another resident in the facility being abused. She reported an employee, named (female name) told a resident, "I don't have time for your s---." Resident #28 stated this occurred "last week" in the "back area" of the facility. She stated she was in bed at the time, but her door was open. She indicated she did not tell staff because, "nothing would be done."			

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	The Administrator of the facility was informed of Resident #28's above allegation of an employee cursing at a resident, on 8/23/16 at 12:27 p.m., along with 3 other allegations from other residents. An interview was conducted with the Administrator on 8/25/16 at 9:33 a.m., to follow up on Resident #28's allegation. He indicated he tried to speak with Resident #28 about her allegation, but did not ask her about her statement regarding an employee cursing at a resident. He indicated, "When I got ready to ask her about it, she said I need to get her t.v. fixed. I don't consider what (name of Resident #28) said as an allegation of abuse, because I don't have an actual staff person indicated." The Abuse & Neglect policy was provided by the Administrator on 8/24/16 at 2:41 p.m. It indicated, "Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." It indicated, "Identification...The staff will identify events, occurrences, patterns, and trends that may constitute abuse and to			

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	determine the direction of the investigation." The 8/25/16, 10:30 a.m. Incident Report indicated, "Brief Description of Incident: Description added -- 8/25/16 ISDPH (sic) conducting annual survey. Surveyor requested administrator to interview resident 20-1 (Resident #28). Administrator went to interview resident. Resident did acknowledge any abuse to administrator verbally, physically sexually or any other type of abuse. Resident did not state any fear or other conditioner (sic) by the interview." This report was submitted to the ISDH on 8/25/16 by the Administrator, 2 days after Resident #28's allegation was reported to the facility. The Abuse & Neglect policy was provided by the Administrator on 8/24/16 at 2:41 p.m. It indicated, "Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law." An interview was conducted with the Administrator on 8/25/16 at 5:59 p.m. He stated he spoke to Resident #28 on 8/23/16, but her only concern was with her t.v., and she didn't say anything about abuse. He indicated he did not attempt to			

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	reinterview her on 8/24/16, because he was following up on other things. He reported he did not designate another staff member to do the investigation. The Abuse & Neglect policy was provided by the Administrator on 8/24/16 at 2:41 p.m. It indicated, "Investigation...The facility will designate someone to investigate the allegations and report the results of the investigation to the administrator or his/her designated representative and to other officials in accordance with State law." An interview was conducted with the SSD (Social Services Director) on 8/25/16 at 9:56 a.m. She indicated she, the Administrator, and Activity Director just finished talking to Resident #28. The SSD reported Resident #28 informed them she had not witnessed any abuse to any other resident. The SSD stated Resident #28 used to have a care plan for making false allegations against staff, but she discontinued it at her last care plan meeting a few weeks ago, because Resident #28 was no longer doing that. The SSD informed there was a CNA (Certified Nursing Assistant) named (female name sounding similar to name given by Resident #28), and perhaps, that was who Resident #28 was referencing.			

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	An interview was conducted with the Administrator on 8/25/16 at 10:43 a.m. He indicated Resident #28 informed him she never heard any staff person abusing a resident. He stated he was getting the impression from Resident #28 that she didn't want to get anyone in trouble, because she was unsure if it was a resident or staff. An interview was conducted with Resident #28 on 8/29/16 at 9:21 a.m. She indicated the information regarding an aide cursing at another resident was heresay from another staff member, but she couldn't remember who. She stated she did not see or hear an aide curse at another resident. She indicated the Administrator, Activity Director, and SSD came in and spoke with her about the allegation the previous week, a day or 2 after she reported it. She stated she felt uncomfortable and intimidated talking to staff about allegations of abuse, because she felt like she might be retaliated against. She stated it seemed to her like the facility would believe a staff member over a resident. An interview was conducted with the Administrator on 8/25/16 at 3:23 p.m. He stated the investigation for Resident #28's allegation and several other			

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	allegations "all ran together", so he only had one investigation, and provided it at this time. The information pertaining to Resident #28's allegation, included in the investigation, were the 8/25/16, 10:30 a.m. incident report, an 8/25/16 interview with Resident #28, an interview with CNA #5, an 8/25/16 summary of an interview with Resident #28 written by the Activity Director, and an 8/25/16 summary of an interview with Resident #28 written by the SSD. The Administrator indicated the investigation was complete, except for a summary of findings, and the abuse was unsubstantiated. The Abuse & Neglect policy was provided by the Administrator on 8/24/16 at 2:41 p.m. It indicated, "Protection...The facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified, that person will be suspended pending investigation in accordance with the progressive discipline policy." 3.1-28(a)			

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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based observation, interview, and record review, the facility failed to maintain a resident's dignity by keeping a urine collection bag covered, sit at eye level while assisting a resident eating, and cleaning up a puddle of urine timely for 2 of 3 residents reviewed for dignity. (Residents #20 and #32) Findings include: 1. During the following observations of the front dining room, Resident #32's urine collection bag was noted visible to other residents in the vicinity: 8/23/16 at 11:06 a.m., 8/23/16 at 12:31 p.m., 8/23/16 at 12:42 p.m., 8/24/16 at 9:33 a.m. 8/25/16 at 8:57 a.m., 8/25/16 at 9:49 a.m., & 8/25/16 at 10:38 a.m. On 8/25/16 at 10:38 a.m., the Regional Director of Clinical Operations (RDCO)	F 0241	F241 The facility does promote care for residents in a mannerand in an environment that maintains or enhances each resident's dignity andrespect in full recognition of his or her individuality. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #32's urine collection bag now has a dignity bagcovering it. Resident #20 no longer has a puddle of urine under theirw/c and his/her room is free of a strong odor of urine. His/her eyeglasses have been thoroughlycleansed of urine. Resident #32 now has staff sit at eye level whenreceiving feeding assistance. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken?** All residents with urine collection	09/30/2016

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	observed Resident #32's urine collection uncovered in the front dining room. She indicated at this time, the urine collection bag should be place in a "dignity" bag to promote dignity for the resident. 2. During a random observation from the hallway, on 8/25/16 at 4:23 p.m, a large puddle of liquid spanning from Resident #20 feet to the backside of Resident #20's wheelchair was observed. Upon stepping into Resident #20's room, a strong odor of urine was present. Staff members were observed walking in the hallway in front of Resident #20's room. On 8/25/16, at 4:37 p.m., during an observation from the hallway, the puddle was still noted under Resident #20's wheelchair. Resident #20's glasses were observed on the floor near Resident #20's wheelchair and the puddle. QMA #6 was preparing medication in front of Resident #20's room. On 8/25/16 at 4:57 p.m., the puddle was observed, from the hallway, near Resident #20's wheelchair. The Regional Director of Clinical Operations and the Business Office Manager walked by Resident #20's room at this time. At 4:59 p.m., on 8/25/16, Therapy #6 was observed walking into Resident #20's		bags, incontinenceand/or receiving feeding assistance are at potential risk from this allegeddeficient practice. All residents with urine collection bags have dignitybags covering them. Urine, feces, food, etc… will be cleaned promptly fromaround any resident when noted Staff now sit at eye level when providing feedingassistance to a resident. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Nursing staff will be in-serviced by the DON/Designee onmaintaining dignity for residents at all times. The in-service will includecovering urine collection bags with dignity covers and sitting at eye levelwhen providing feeding assistance to a resident. All department's staff in-serviced byAdministrator/Designee on maintaining a clean environment at all times to helppromote dignity for each resident. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?**	

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	room. During an observation with CNA #8, on 8/25/16 at 5:03 p.m., CNA #8 indicated the puddle under Resident #20's wheelchair was urine and Resident #20 was soiled. 3. During an observation, on 8/23/16 at 12:34 p.m., QMA #1 was observed standing next to Resident #32, spooning several bites of food into his mouth. QMA #1 was not observed to be at eye level with Resident #32 at this time. Chairs were noted to be stacked behind QMA #1 and within easy reach. QMA #1 was observed going over to another resident and rubbed their back. Then QMA #1 walked back over to Resident #32 and stood next to Resident #32's wheelchair. QMA #1 spooned several more bites of food into Resident #32's mouth. QMA #1 was not at eye level with Resident #32 at this time. The Director of Nursing was observed going over to QMA #1 and spoke to QMA #1. QMA #1 then went to grab a chair and pulled it next to Resident #32. QMA #1 proceeded to spoon several bites of food into Resident #32's mouth, while seated in a chair, at this time. A policy titled, Promoting/Maintaining Resident Dignity, no date, was provided		The Administrator/Designee will perform walking roundsdaily x 1 mo then a minimum of weekly thereafter, ongoing to ensure urinecollection bags are covered and spills are promptly cleaned. Each round will include review of at leastone meal service to ensure staff are sitting at eye level while providing feedingassistance. Deficient practices will beaddressed immediately. The Administrator/Designee will report theirfindings monthly to the facility QAA team who will determine the need/frequencyof further monitoring after 6 months and/or if changes in monitoring need tooccur based on results.	

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	155721	A. BUILDING 00 B. WING	08/31/2016

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	by the RDCO, on 8/25/16 at 11:12 a.m. The policy indicated, "It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. 1. All staff members are involved in providing care to residents to promote and maintain resident's dignity...." 3.1-3(t)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to invite residents and	F 0280	F 280 Right to Participate Planning Care Plan Revised,	09/30/2016

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	family members to care plan meetings and to update a behavior care plan for 3 of 3 residents reviewed for participation in care planning and 1 of 3 residents reviewed for activities of daily living (Residents #10, #14, #30 and #44). Findings include: 1. The clinical record for Resident #44 was reviewed on 8/23/16 at 2:00 p.m. The diagnoses for Resident #44 included, but were not limited to, paranoid schizophrenia and dementia. She was admitted to the facility on 6/29/16. A telephone interview was conducted with Family Member #20 on 8/24/16 at 10:09 a.m. She indicated staff did not include her in decisions about Resident #44's medicine, therapy or other treatments. She stated, "They haven't talked to me about her medications, therapy or treatments since she's been there. I've never been to a care plan meeting there, and I don't recall getting an invitation." An interview was conducted with the SSD (Social Services Director) on 8/30/16 at 2:51 p.m. She indicated the process for inviting family members to care plan meetings was to send out letters informing them, but "I haven't been on		It is the policy of the Lawrence Manor to have the resident exercise their right unless adjusted incompetent or otherwise found to be incapacitated under the laws of the state to participate in planning care and treatment or changes in treatment. Participate the facility to provide the resident with activities of daily living and necessary services to maintain good nutrition grooming and personal and oral hygiene. **Corrective Action Taken Related to this Finding** Resident # 44 family member has received the process for invitation to the care plans. Care plan notification mailed in advance of the care plan as well as family verbally notified. Family participation is encouraged as well as helpful in the care plan process. Resident # 14 and resident # 10 care plans reviewed with both residents, now each has the resident signature on their individual care plan. Resident # 30 care planned for removing socks, staff will continue to offer residents sock as part of her care. Resident # 30 has had an additional assessment completed by Assurance to determine the resident's baseline, Medical Director also made assessment on resident to address resident behavior. Lawrence Manor has provided additional consultation service for the SSD and as well as the facility policy with training for the SSD. Facility following the schedule care	

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	top of that as I should. I've been calling families via telephone. I haven't had a chance to send any letters. We had 11 admissions last month, which was very overwhelming....I honestly, probably, did not send her (Family Member #20) an invitation to a care plan meeting. I don't have an address for her family. I did not call and try to get one. Her care plan meeting would have been within a couple of weeks after admission. I don't have her niece's (Family Member #20) address on file. I don't remember if her niece came or not. We should be sending invitations to family prior to care plan meetings." The 7/13/16 nurse's note for Resident #44 indicated her care plan meeting was held. Resident #44 had No BIMS (brief interview for mental status) score due to Resident #44 being rarely/never understood. The 7/13/16 Care Plan Signature Sheet did not include signatures of Resident #44 or Family Member #20, only staff signatures. A telephone interview was conducted with Family Member #20 on 8/31/16 at 9:57 a.m. She indicated she was not invited to Resident #44's 7/13/16 care		plan to notify the families of the care plan, Facility has implemented corrective action to the staff person assigned to give care to the resident. Follow up in-service training on regular schedule basis to SSD form the consultant. The facility updated the resident care plan and the resident's preference sheets with regard to resident choice. **II. Other Residents with Potential to be affected by this finding will be identified by:** The facility has completed behavior assessments along with modifying the care plans on all the resident population at Lawrence Manor No other residents were affected by practice. **III. Measures and Systemic Changes put into Place to Assure /Deficit Practices do not recur are as Follows:** Lawrence Manor implemented daily audit sheets for care plans schedules, and documented verbal notification, for the care plans. Completed scheduled audit sheets review at the morning QA meeting, on an on-going basis. Audit sheets implemented with monitoring by the administrator. The facility will continue to involve family representation resident choice for their signature on the care plans. **IV. Corrective Actions will be monitored to Ensure Compliance by:** The Administrator will observe	

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	plan meeting. She stated, "They didn't even have my address. They did not call me and invite me either..." An interview was conducted with the SSD on 8/30/16 at 3:31 p.m. She stated, "I remember talking to (name of Family Member #20), but I don't remember asking her to go to a care plan meeting." 2. The clinical record for Resident #14 was reviewed on 8/23/16 at 2:00 p.m. The diagnoses for Resident #14 included, but were not limited to, hemiplegia. An interview was conducted with Resident #14 on 8/23/16 at 2:05 p.m. She indicated staff did not include her in decisions about her medicine, therapy, or other treatments. She stated they make decisions about her care and don't check with her or let her know, and did not recall going to her care plan meetings. An interview was conducted with the SSD (Social Services Director) on 8/31/16 at 12:43 p.m. The SSD indicated Resident #14 would sign her (Resident #14) name on the signature log, if she (Resident #14) attended her care plan meeting. The SSD indicated she had no verification Resident #14 attended or was invited to her last care plan meeting.		compliance the QA daily meeting and review of the audit sheets, Care Plan schedules reviewed daily with audit forms then weekly x 3 weeks, then monthly x 5 months. The Administrator will report findings to the QA committee monthly who will then decide on continued need and/or frequency of monitoring after 6 months.	

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	The 8/4/16 Care Plan Signature Sheet for Resident #14 was not signed by Resident #14, only staff. 3. The clinical record for Resident #10 was reviewed on 8/23/16 at 12:00 p.m. The diagnoses for Resident #14 included, but were not limited to, end stage renal disease. An interview was conducted with Resident #10 on 8/23/16 at 12:13 p.m. She indicated staff did not include her in decisions about her medicine, therapy, or other treatments. She stated the facility gave her her medications. An interview was conducted with the SSD (Social Services Director) on 8/31/16 at 12:43 p.m. The SSD indicated Resident #10 would sign her (Resident #10) name on the signature log, if she (Resident #10) attended her care plan meeting. The SSD indicated she had no verification Resident #10 attended or was invited to her last care plan meeting. The 8/10/16 Care Plan Signature Sheet for Resident #10 was not signed by Resident #10, only staff. 4. The clinical record for Resident #30 was reviewed on 8/31/16 at 2:30 p.m. The diagnoses for Resident #30 included,			

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	but were not limited to: schizophrenia, anxiety, and psychosis. A quarterly MDS (material data set) assessment dated 4/12/16, indicated Resident #30 was total dependence with 1 person assistance with dressing. A behavior care plan dated 6/26/16, indicated Resident #30 was "...verbally abusive..as evidenced by: Yelling, screaming, hallucinations/delusions..." A behavior care plan dated 6/26/16, indicated Resident #30 "had episodes of yelling throughout the facility due to hallucinations/delusions..." A "BEHAVIOR MANAGEMENT RECORD" indicated "Behaviors Identified/Known to Exhibit 1. Demanding Behavior/Attention-seeking behavior. 2. Delusions/hallucinations. 3. Difficulty to redirect. 4. Cursing staff/residents. 5. Yelling/Screaming. 6. throwing things @ staff. 7. lying (sic)..." A behavior note dated, 8/26/16 at 2:30 p.m. indicated Resident #30 refused to let staff assist with putting her socks and shoes on. Resident #30 had stated to staff,"I'll kick you if you try." An observation was made of Resident			

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	#30 on 8/26/16 at 2:30 p.m. Resident #30 was observed in wheelchair propelling down the hall with no socks or shoes. An observation was made of Resident #30 on 8/30/16 at 8:30 a.m. Resident #30 was observed in her wheelchair propelling around the business office with no socks or shoes. An observation was made of Resident #30 on 8/30/16 at 9:30 a.m. Resident #30 was propelling in her wheelchair around the nurses station with no socks or shoes on her feet. An observation was made of Resident #30 on 8/30/16 at 11:25 a.m. Resident #30 was propelling in her wheelchair in the hallway with no socks or shoes. An observation was made of Resident #30 on 8/30/16 at 3:30 p.m. Resident #30 was propelling in her wheelchair in the hallway with no socks or shoes. An interview was conducted with Qualified Nursing Assistant (QMA) #5 on 8/31/16 at 1:30 p.m. She indicated Resident #30 takes her socks off all the time, and the staff does make several attempts to place them back on.			

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	The 8/30/16 Care Plan Interdisciplinary Team policy was provided by the Regional Director of Operations on 8/30/16 at 3:37 p.m. It read, "The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan." 3.1-35(d)(2)(B) 3.1-35(c)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to assess a resident before and after going to dialysis per policy, have a water pitcher at bedside as care planned, and have a dilantin level drawn as ordered, for 1 of 5 residents reviewed for unnecessary medications, 1 of 1 residents reviewed for dialysis, and 1 of 2 residents reviewed for hydration.(Residents #9, #10, and #23)	F 0282	F282 The facility does provide and arrange services byqualified persons in accordance with each resident's plan of care. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #10 now has the Dialysis Assessment Formcompleted prior to and upon return from each dialysis session. Resident #23 now has a water pitcher in their room. Resident	09/30/2016

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	Findings include: 1. The clinical record for Resident #10 was reviewed on 8/25/16 at 12:30 p.m. The diagnoses included, but were not limited to, end stage renal disease, schizoaffective disorder, and dependent on renal dialysis. The record showed the following orders: " Dialysis at [name of dialysis center] on Tues [Tuesday], Thurs [Thursday], and Sat [Saturday] " initiated on 7/29/16. " Double lumen Rt [right] - Fem [femoral] " with no initiation date. A form titled " DIALYSIS ASSESSMENT " was provided by the DON (Director of Nursing) on 8/30/16 at 10:33 a.m. The assessment form indicated the following, " ...Date ...Before Dialysis ....B/P [Blood Pressure], T [Temperature, P [Pulse], R [Respirations] ...Dressing present and intact [mark yes or no] ...Site [mark pink free of complications, reddened, swelling, other] ...Edema [mark yes or no] ...SOB [shortness of breath] [mark yes or no]...Bleeding [mark yes or no]...." There was an "After Dialysis" category present as well with the same assessment information.		#9's Dilantin level was drawn on 08/31/16 andthe pcp was notified of missed draw??? **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken?** Any resident on dialysis and/or not on fluid restrictionand/or have orders for lab work are potentially at risk for this allegeddeficient practice. A review was made of all residents receiving dialysis toensure a Dialysis Assessment Form was available and being completed before andafter dialysis. A room check was completed for resident's not on fluidrestriction to ensure all had water pitchers available. A list has been compiled and made availableto nursing staff of any resident that should not have a water pitcher in theirroom, and CPs have been updated to match if needed. An audit was completed by DON/Designee of all residentlab orders. Any other identified, missedlab was promptly re-scheduled for the next lab draw day. Lab tracking binder to be reviewed daily on business daysby DON. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed Nurses have been in-serviced by the DON/Designeeon completing pre and post dialysis assessments on	

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	The DIALYSIS ASSESSMENT FORM did not have blood pressure, temperature, pulse, and respirations documented on the following days: 7/2/16- before and after dialysis 7/5/16- before and after dialysis 7/7/16- before dialysis 7/9/16- before dialysis 7/12/16- before dialysis 7/14/16- before dialysis 7/30/16- before dialysis 8/4/16- after dialysis 8/6/16- after dialysis 8/9/16- before and after dialysis 8/11/16- before and after dialysis 8/13/16- before and after dialysis 8/16/16- before dialysis 8/18/16- before dialysis 8/20/16- before dialysis 8/23/16- before dialysis 8/25/16- before and after dialysis 8/27/16- before and after dialysis A Care Plan for Resident #10, revised 8/10/16, indicated the following, " [Resident #10 ' s name] needs dialysis r/t [related to] her End Stage Renal Failure ...Interventions: ...Obtain vital signs and weight per protocol or as ordered .... " An interview was conducted with RN #8 on 8/29/16 at 3:36 p.m. She indicated when Resident #10 arrives back to the		any resident receivingdialysis and ensuring completion of physician ordered laboratory work. Nursing staff in-serviced by DON/Designee on providingadequate hydration for residents and location of list of who should not have awater pitcher in their room. **How the correctiveaction(s) 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 audit the Dialysis Assessment Formon all dialysis residents 3 x week x 1 month then 3x every other week x 1month, then monthly thereafter x 4 more months. Deficient areas will be addressed immediately. The DON/Designee will perform walking rounds daily x 1mo, then weekly x 1 mo then monthly thereafter x 4 more months to ensure waterpitchers available to designated residents. The DON/Designee will also ensure the available list of residents tohave water pitchers is up to date at this time. Deficient areas will be corrected immediately. The DON/Designee will select 5 resident charts per week x4 weeks, then 5 resident charts bi-weekly x 1 month, then 5 resident chartsmonthly for the next 4 months to ensure no further missing laboratorywork. Deficient areas will be correctedimmediately. The	

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	facility from dialysis the staff obtain vital signs and check her dialysis catheter site to note any swelling or redness. The dialysis sheet in Resident #10's chart is what is utilized to document the vital signs and condition of the dialysis catheter. An interview was conducted with the DON on 8/30/16 at 11:10 a.m. She indicated her expectations are for nursing staff to complete the dialysis assessment prior to going to dialysis and after returning from dialysis. A policy titled " Hemodialysis, Care of Residents " , revised June, 2008, was provided by the RDO (Regional Director of Operations) on 8/30/16 at 8:30 a.m. The policy indicated the following, " ...Post Hemodialysis/ Ongoing Care: ...1. Check vital signs every shift for the 24 hours post-dialysis or per physicians order ...Documentation ...1. Dialysis Communication Record ...2. Nurse ' s notes - key documentation elements: ...Vital Signs .... " 2. The clinical record for Resident #23 was reviewed on 8/25/16 at 10:00 a.m. The diagnoses included, but were not limited to, sepsis, diabetes mellitus, and multiple sclerosis.		DON/Designee will report their findings monthly tothe facility QAA team who will determine the need/frequency of furthermonitoring after 6 months and/or if changes in monitoring need to occur basedon results.	

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	A " Dietary Order " for Resident #23, no date, stated a " puree diet with thin liquids as tolerated. " An Admission MDS (Minimum Data Set) Assessment, completed for Resident #23 on 8/12/16, indicated a BIMS (Brief Interview for Mental Status) score of 14 of 15 indicating Resident #23 was cognitively intact. The MDS also indicated the following, " ...Eating: extensive assist [assistance] x1 [time one] ...Bed mobility: extensive assist [assistance] x2 [times two] .... " An observation was conducted on 8/23/16 at 11:39 a.m. indicating Resident #23 had no water pitcher in her room. A Care Plan for Resident #23, initiated 8/24/16, indicated the following, " [Resident #23 ' s name] has a potential for dehydration r/t [related to] diuretic use r/t [related to] edema ...Interventions ...Keep fresh ice water at bedside within easy reach q [every] day ...Monitor and document intake and output as per facility policy .... " Observations were conducted on the following days where Resident #23 did not have a water pitcher at bedside: 8/25/16 at 3:50 p.m.,			

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	8/30/16 at 4:00 p.m., 8/31/16 at 9:00 a.m., & 8/31/16 at 2:05 p.m. An interview was conducted with Resident #23 on 8/30/16 at 4:02 p.m. She indicated she would like to have water at the bedside and expressing that she is thirsty. An interview was conducted with the DON on 8/31/16 at 2:02 p.m. She indicated Resident #23 is not on a fluid restriction or thickened liquids diet where Resident #23 could not have a water pitcher at her bedside. An interview was conducted with QMA (Qualified Medication Aide) #1 on 8/31/16 at 2:05 p.m. She indicated Resident #23 is on regular liquids and there is no reason she cannot have a water pitcher at bedside. QMA #1 further indicated some of the water pitchers got damaged and the facility has ordered some and believes that is why Resident #23 does not have a water pitcher. A policy titled " Oral Nutrition & Hydration " , revised June, 2008, indicated the following, " ...7. Drinking water is provided to encourage adequate fluid intake. Provide fluids to residents during and in-between meals and during			

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	activities as appropriate. Before serving drinking water to the resident, verify that the resident is not NPO [nothing by mouth]; is on restricted fluids; is not on thickened liquids; and can have ice. Residents who cannot have ice may receive tap water only. Fresh water and ice are provided at bedside, within the resident ' s reach, unless contraindicated .... " 3. The clinical record for Resident #9 was reviewed on 8/29/16 at 2:00 p.m. The diagnoses for Resident #9 included, but were not limited to: dementia and seizure disorder. A physician order dated 5/2/16, indicated Resident #9 was to be given "...Dilatin 100 mg (milligrams) capsule Give 3 capsules (300mg) by mouth at bedtime for seizure disorder." A physician order dated 8/5/16, indicated to staff, "...2) Start Dilatin level now then q (every) 3 months in Jan, (January) April, July, October..." for Resident #9. An interview was conducted with the Director of Nursing (DON) on 8/30/16 at 9:29 a.m. She reported Resident #9's dilatin level had been missed being drawn. A "PHYSICIAN ORDER TRANSCRIPTION AND PROCESSING			

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	POLICY AND PROCEDURE" indicated, "Policy. Physician orders will be transcribed and processed in accordance with professional standards..." 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident's pain was evaluated and treated by a pain specialist for 1 of 3 residents reviewed for pain. (Resident #34) Findings include: The clinical record for Resident #34 was reviewed on 8/29/16 at 2:00 p.m. The diagnosis for Resident #34 included, but was not limited to: stroke. A physician order dated 8/19/16, indicated the staff was to schedule an	F 0309	F309 The facility does ensure that each resident receives andthe facility does provide the necessary care and services to attain or maintainthe highest practicable physical, mental, and psychosocial well-being, inaccordance with the comprehensive assessment and plan of care. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #34 has an appointment at	09/30/2016

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	evaluation and treatment at (name of hospital) pain clinic for Resident #34. A physician order dated 8/26/16, indicated Resident #34 was to receive 7.5/325 milligrams of percocet every 6 hours as needed for pain. An interview was conducted with Resident #34 on 8/23/16 at 2:22 p.m. She reported she had left shoulder and left leg pain that was effected by her stroke. She indicated her pain is normally rated at a 7. An interview was conducted with RN #8 at 12:09 p.m. She stated she had contacted the (name of hospital) pain clinic, on 8/22/16, and was informed the facility did not have a pain clinic. She then reported this information to Resident #34's physician on 8/22/16 and was given a verbal order to contact another facility's pain clinic to schedule Resident #34 to be seen. RN #8 indicated she had forgotten to write the order and the appointment was never made for Resident #34 to be seen at a pain clinic. 3.1-37(a)		a pain clinicscheduled for 10/24/16 @ 10:30 am. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken?** This alleged deficient practice had the potential toaffect any resident experiencing pain. An audit was completed by DON/Designee of all residentcharts to ensure no other recommendations/orders from the physician have beenmissed. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed nurses in-serviced by DON/Designee on importanceof transcribing orders at the time they are received. All new orders are to be noted on the facility 24-hournurse's communication sheet as well as transcribed into the resident's currentmedical record. The new orders from theprevious day will be checked by the DON to ensure accuracy. The lab binder willbe checked daily by DON to ensure orders, obtained and results are received.	

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			How the correctiveaction(s) 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 select 5 resident charts per week x4 weeks, then 5 resident charts bi-weekly x 1 month, then 5 resident chartsmonthly for the next 4 months to ensure no further missed appointments ororders. The 24 hour sheets will be usedto compare to the resident's medical record. Deficient areas will be corrected immediately. The DON/Designee will report findingsmonthly to the facility QAA team who will determine the need/frequency offurther monitoring after 6 months and/or if changes in monitoring need to occurbased on results.	
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide nail care to 1 of 3 residents reviewed for activities of daily living. (Resident #9)	F 0312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS It is the policy of the Lawrence Manor the facility to provide the resident with activities of daily living and necessary services to maintain good nutrition grooming and personal and oral hygiene.	09/30/2016

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	Findings include: The clinical record for Resident #9 was reviewed on 8/29/16 at 2:00 p.m. The diagnoses for Resident #9 included, but were not limited to: dementia and seizure disorder. A quarterly MDS (material data set) assessment dated 7/1/16, indicated Resident #9 was total dependence with 1 person assistance for personal hygiene. A care plan date initiated 8/27/15, indicated Resident #9 "needs assist with his bathing, dressing and personal hygiene skills r/t (related to) weakness, loss of balance and cognitive deficits due to his Dementia with behaviors dx (diagnosis) and Obesity." Interventions included, but was not limited to: "..Assist with shaving and nail care daily prn (as needed)..." An August "ADL (activities daily living) DAILY DOCUMENTATION" was provided on 8/30/16 at 4:35 p.m. by the Director of Nursing (DON). Resident #9 was provided nail care on the following days: 8/3, 8/4, 8/10, 8/11, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27, 8/28, and 8/29. An observation was made of Resident #9		**Corrective Action Taken Related to this Finding** Resident #9 was asked if the facility staff could cut his nail on 08/29/16 and the resident gave permission for Lawrence manor staff tocut it. The Facility has implemented corrective action to the staff person assigned to give care to the resident. In service provided to nursing staff on providing care to the dependent population The facility updated the resident care plan and the resident's preference sheets with regard to resident choice. **II. Other Residents with Potential to be affected by this finding will be identified by:** The assessments and care plans where all residents had the potential to be affected by this alleged deficient practice **III. Measures and Systemic Changes put into Place to Assure /Deficit Practices do not recur areas Follows:** Lawrence Manor utilizing the ADL audit sheets and compliance forms for monitoring staff that completion of the residents in need of personal care. **IV. Corrective Actions will be monitored to Ensure Compliance by:** The Administrator will observe compliance via daily walking rounds and review daily with audit forms then weekly x 3 weeks, then monthly x5 months. The Administrator will report findings to the QA committee monthly who will then decide on continued	

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	on 8/23/16 at 3:25 p.m. All of Resident #9's fingernails were observed long in length. His fingernails had grown passed the tip of his fingers. Resident #9's index finger was curling inward and left thumbnail was jagged and chipped. An observation was made of Resident #9 on 8/30/16 at 3:58 p.m. Resident #9's fingernails were observed long in length. Resident #9's fingers were packed with brown substance and index fingernail was curling inward and left thumbnail nail jagged and chipped. An interview was conducted with Certified Nursing Assistant (CNA) #8 on 8/30/16 at 4:15 p.m. She indicated she provides nail care to Resident #9 after each meal, because he digs in his food during meal times. At this time, CNA #8 observed Resident #9's fingernails. She stated Resident #9's fingernails were pretty long and was not sure why his nails had not been trimmed. It wasn't difficult to trim Resident #9's nails. CNA #8 indicated nail trimming was provided during nail care. An interview was conducted with the Director of Nursing (DON) on 8/39/16 at 4:45 p.m. She indicated Resident #9's fingernails were long in length and needed to be trimmed. She reported it is		need and/or frequency of monitoring after 6months.	

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	the preference of the resident if his or her nails need to be trimmed. At this time, she asked Resident #9 if he would mind if the staff trimmed his nails. Resident #9 responded, "I don't care." The DON stated the staff probably hadn't asked Resident #9 if he would like his nails trimmed. A "Care of Fingernails/Toenails" policy was provided by the Regional Director of Operations at 8/31/16 at 8:34 a.m. It indicated, "Purpose. The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed...4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin...." 3.1-18(a)(3)(A)(B)(C)(D)(E)			

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F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to do weekly assessments of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident #23) Findings include: The clinical record for Resident #23 was reviewed on 8/25/16 at 10:00 a.m. The diagnoses included, but were not limited to, diabetes mellitus and unstageable pressure ulcer to left heel. A document titled " WEEKLY PRESSURE ULCER RECORD " was provided by the Regional Director of Clinical Operations on 8/31/16 at 10:50 a.m. The document indicated measurements were obtained on the following days:	F 0314	F314 Based on the comprehensive assessment of a resident, the facility does ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing,prevent infection and prevent new sores from developing. **What correctiveaction(s) will be accomplished for those residents found to have been affected bythe deficient practice?** Resident #23 has her wound measured, and the resultsdocumented, a minimum of weekly. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will**	09/30/2016

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	8/6/16- 1.5 x 1.5 centimeters, 8/10/16- 1.5 x 1.5 centimeters, & 8/17/16- 1.5 x 1.5 centimeters. There were no other weekly wound measurements that could be located in Resident #23's clinical record. A care plan, initiated 8/24/16, indicated the following, "[Resident #23's name] was admitted with an unstageable pressure ulcer to her left heel ...Interventions ...Assess/record/monitor would healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD .... " An interview was conducted with the DON on 8/31/16 at 2:02 p.m. She indicated there is no further documentation in regards to measurements of Resident #23's pressure area. She further indicated measurements should be completed weekly. A policy titled "Skin Management", revised November, 2014, was provided by the Vice President of Operations on 8/31/16 at 4:03 p.m. The policy indicated the following, "...Residents admitted with		**be taken?** Any resident with pressure ulcers is at risk for thisalleged deficient practice. A review was made of all residents with pressure ulcersto ensure weekly measurements are taking place and the results are being documented. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed nurses in-serviced by the DON/Designee onrequired documentation for residents with pressure ulcers, including weekly measurements and characteristics. **How the correctiveaction(s) 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 a copy of thefacility “wound report” weekly to ensure measurements and characteristics of all pressure ulcers have been documented. This will be ongoing and any deficient area will be addressed immediately. The DON/Designee will report findings monthly to the facility QAA team a minimum of 6 months. After 6 months, the QAA team will determinethe frequency of continued monitoring based on results.	

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	skin impairments will have: Wound location and characteristics documented in the Nursing Notes;...In addition, the following forms are completed and placed with the resident's Treatment Record: ...Pressure Ulcer: Weekly Pressure Ulcer Record...." 3.1-40(a)(2)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to change a resident's urinary catheter timely, as ordered, for 1 of 1 resident randomly reviewed for urinary catheter use. (Resident #28) Findings include: The clinical record for Resident #28 was reviewed on 8/23/16 at 10:30 a.m. The diagnoses for Resident #28 included, but were not limited to, neurogenic bladder	F 0315	F315 Based on the resident's comprehensive assessment, the facility does ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinicalcondition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as	09/30/2016

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	and paraplegia. The indwelling foley catheter care plan, revised 8/10/16, indicated the goal was for Resident #28 to show no signs or symptoms of a urinary tract infection. It indicated, "Change foley catheter every month and prn (as needed) if not patent." It indicated, "Obtain orders for U/A (urinalysis) with C&S (culture and sensitivity) and labs as needed." The 8/26/16 Physician's Order for Resident #28 indicated, "Anchor new Foley catheter. Send U/A C&S in a.m. (morning) - fever, dysuria - take from new Foley." An interview was conducted with Resident #28 on 8/30/16 at 11:11 a.m. She indicated the nurse practitioner wrote an order to change her catheter and get a sample on Friday (8/26/16), and it still hadn't been done. She indicated, "I don't feel well. I think I have a UTI (urinary tract infection). I start to act different when I get a UTI, and I don't even realize it." An interview was conducted with RN #8 on 8/30/16 at 11:48 a.m. She indicated agency nursing staff was in the building over the weekend, and they did not change Resident #28's catheter, but took		much normal bladder functionas possible. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #28 had a new Foley catheter inserted on08/31/16 and a new urine specimen was sent to the lab after the new catheter inserted. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken?** Any resident with an indwelling catheter is at risk for this alleged deficient practice. A review was made of the medical records of all other residents with indwelling catheters. Any catheter that was past the physician ordered time frame to be changed, had their indwelling catheter changed. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed Nurses in-serviced on following physician orders with an emphasis on changing indwelling catheters as ordered by the physician.	

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	the urine specimen anyways, and sent it in, even though the order specifically said to take specimen from the new catheter. An interview was conducted with the DON on 8/30/16 at 11:56 a.m. She indicated she thought the facility only had one nurse capable of changing Resident #28's catheter. She indicated that particular nurse worked the previous evening, but she may not have known a new catheter needed placed. An interview was conducted with Resident #28 on 8/30/16 at 12:48 p.m. She stated, "This morning was the first time they tried to place a catheter." The Urinary Catheter Care policy was provided by the DON on 8/30/16 at 12:54 p.m. It read, "The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable)." 3.1-41(a)(2)		**How the correctiveaction(s) 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 TARs weekly x 1 mo,then bi-weekly x 1 mo and then monthly x 4 more months to ensure indwelling catheters were changed as ordered by the physician. Deficient areas will be corrected immediately. The DON/Designee willreport findings monthly to the facility QAA team a minimum of 6 months. After 6 months, the QAA team will determinethe frequency of continued monitoring based on results.	
F 0323 SS=E	483.25(h) FREE OF ACCIDENT			

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Bldg. 00	HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement interventions for a resident identified as at risk for elopement, per policy, and to ensure a maintenance cart containing tools and chemicals was not left unattended for 1 of 3 residents reviewed for accidents and 4 of 13 residents on the front hall of the facility. (Residents #14, #20, #27, #44, and #53) Findings include: 1. The clinical record for Resident #44 was reviewed on 8/23/16 at 2:00 p.m. The diagnoses for Resident #44 included, but were not limited to, paranoid schizophrenia and dementia. She was admitted to the facility on 6/29/16 from another extended care facility. The 7/8/16 Admission MDS (minimum data set) assessment for Resident #44 indicated she wandered, and was at risk of getting to a dangerous place. An interview was conducted with the MDS Coordinator on 8/30/16 at 3:25 p.m. She stated, "She does wander	F 0323	**F323** **1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The elopement risk binder was reviewed and it is up to date. The building was scanned for any potential hazard chemicals and is now free. **2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?** All residents would have the potential to be effected. **3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The admitting nurse will completethe risk assessment upon admission, quarterly, and with significate change. If deemed at risk, a camera is available at alltimes so that a picture may be obtained and placed in the risk book. Duringrounds by admin/designee, observation will be done to ensure the environment remains as free of hazard chemicals.	09/30/2016

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	155721	A. BUILDING 00 B. WING	08/31/2016

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	around the facility, and I have seen her going in residents' rooms." An interview was conducted with the SSD (Social Services Director) on 8/30/16 at 4:01 p.m. She stated, "She wanders into other residents' rooms, follows staff and visitors around building." The 6/29/16 Elopement Risk Assessment for Resident #44 indicated she was at risk for elopement. An interview was conducted with the DON on 8/31/16 at 11:30 a.m. She indicated, after a resident was assessed as being at risk for elopement, the information went into an elopement binder. The elopement binder was reviewed with the RDCO (Regional Director of Clinical Operations) on 8/31/16 at 11:31 a.m. The binder contained a Missing Person Report Form Part 1 for Resident #44, with a 3 inch by 3 inch square at the bottom of the form that stated "Place Resident Photo Here". There was no photo of Resident #44 on the form. Above the missing photo area of the form was a physical characteristics area. The entries for height, weight, eye color, hair color, mental status, and other identifying		**4) How will the corrective action 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 new admission charts within 24 hours of admission to ensure completion of assessment and missing person form as applicable. The admin/designee will monitor for any hazard chemicals during rounding of facility 5 days per week x 1 month, then 3 x per week x 1 month, then weekly x 1 month, then monthly x 3 months to ensure 100% compliance and results will be presented to QA monthly.	

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	factors were not completed. The Contact Information Section was missing the Responsible Party's address and phone number. The RDCO stated, "The purpose of the binder is for staff to be aware of who is at risk so they can keep an eye out for the resident, and if they go missing, so all the pertinent information is there." The SSD happened to be in the area at this time, and stated, "I don't have a camera to take a picture." The Medication Administration Record (MAR) for Resident #44 was reviewed with QMA (Qualified Medication Aide) #5 on 8/31/16 at 1:10 p.m. There was no picture of Resident #44 in the MAR. QMA #5 stated, "I don't have a picture of her in the MAR. Some residents have a picture and some don't." The 7/3/16 nurses note indicated, "Dietary aide noted res (resident) outside when she took trash out. Res was @ side door. Res was observed @ 7:00 p.m. ambulating hallway in front of N.S. (nurses station). No injury noted. Res smiling, conversation rambling - her norm." A telephone interview was conducted with Family Member #20 on 8/31/16 at 9:54 a.m. She indicated she was unaware of Resident #44 being outside on 7/3/16.			

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	She indicated she informed the facility Resident #44 had "gotten out" at another facility previously. Family Member #20 indicated when she visited the facility, she noticed Resident #44 stood right by the door. Family Member #20 indicated, "Her getting out is a concern of mine." An interview was conducted with the SSD on 8/31/16 at 10:25 a.m. She stated, "She's never gotten out." The SSD reviewed the 7/3/16 nurses note regarding Resident #44 noted outside by a dietary aide. The SSD stated, "I didn't know about that....It's social services responsibility to address elopement risks....I need to talk to the administrator to see that he knows about the situation." An interview was conducted with the Administrator on 8/31/16 at 10:46 a.m. He indicated he was aware of Resident #44 being outside on 7/3/16. He indicated it was his understanding Resident #44 came out of the side door and was directed back inside by a dietary aide. An observation of the outside door to the kitchen was made with the SSD and Administrator on 8/31/16 at 11:02 a.m. The outside door led into the kitchen pantry. The Administrator indicated Resident #44 came through the pantry			

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	door, through the pantry, and out the kitchen door. He stated, "I think staff was out here congregated for some reason. If they had used the side door to come out instead of the kitchen door, (name of Resident #44) may not have gotten outside at that time. A note entitled "(Name of Resident #44) Notes" was provided by the administrator on 8/31/16 at 3:30 p.m. It read, "There were 2 dietary staff working the shift. One dietary staff was still in the kitchen when another staff was outside taking out the trash. The kitchen staff was not sure how the resident came to the dietary pantry or in fact did the resident come thru (sic) the pantry. Entrance door was checked for locking; it locked open and closed inside the frame. Staff in serviced on keeping the pantry room's door locked and not use the door as an exit. Dietary (name of dietary aide) - Stated she was taking trash out back to dumpster and on her way back in she seen (sic) resident (name of Resident #44) standing at the door pulling on it. She then assisted her back in the door and told the nurse." An interview was conducted with the Administrator on 8/31/16 at 3:39, regarding the above note. He indicated to his understanding, Resident #44 was outside pulling on the closed door.			

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	The Elopement Prevention, Identification and Management policy was provided by the Vice President of Operations on 8/31/16 at 12:49 p.m. It indicated, "A Elopement Risk Assessment form for each resident is to be completed upon admission to the facility, quarterly thereafter and with any significant change....Each resident will have their photograph taken during the admission process and this is to be updated as needed. The photograph will be placed in the resident's Medication Administration Record notebook. A photograph will be added to the Elopement Risk Notebook/Missing Person Report Part 1 if they are identified at risk for elopement....If the assessment determines that a resident is at risk for elopement the facility Care Plan Team and Administrative Staff will be notified and the resident's name added to the Potential Elopement List Form and a Missing Person Report Part 1 form completed...." 2. On 8/25/16 at 11:27 a.m., an unattended maintenance cart was observed in Resident's #14 and #34's doorway. The cart contained paint, floor patch, some tools, a trough runner, a paint brush, 2 cans of closed paint, 1 can of open paint, bug spray, dust cleaner,			

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	and WD 40. An interview was conducted with the Maintenance Director on 8/25/16 at 11:31 a.m. He stated, "I don't generally leave the cart, but a resident asked me to push him down the hall." On 8/31/16 at 6:03 p.m., Consultant #9 provided the Material Safety Data Sheets (MSDS) for the following items with the following information: "WD-40 - DANGER! Flammable aerosol. Contents under pressure. Harmful or fatal if swallowed. If swallowed, may be aspirated and cause lung damage. May cause eye irritation. Avoid eye contact. Use with adequate ventilation. Keep away from Heat, sparks and all other sources of ignition." "Cleaning Duster...Eyes...Contact with liquid may cause frostbite. Skin...Contact with liquid may cause frostbite. Inhalation...Excessive intentional inhalation may cause respiratory tract irritation and central nervous system effects (headache, dizziness). Vapors may cause dizziness or suffocation." "Tile Adhesive...Inhalation: Move victim to fresh air. Consult physician if			

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	necessary. Eye contact: Flush with copious amounts of water for at east 15 minutes. Consult physician if necessary. Ingestion: Do not induce vomiting. Wash out with water. Consult physician. Note to physician: Eyes: Stain for evidence of corneal injury. If cornea is burned, instill antibiotic steroid preparation. Skin: Treat symptomatically as for contact dermatitis or thermal burns. If burned, treat as thermal burn. Ingestion: Treat symptomatically. There is no specific antidote....Respiratory: Treatment is essentially symptomatic. Remove individual with symptoms from exposure and assist in breathing if necessary." "Semi-Gloss Enamel...Potential health Effects...Eye: Causes eye irritation. Skin: Causes skin irritation. Inhalation: Prolonged or excessive inhalation may cause respiratory tract irritation. Ingestion: May be harmful if swallowed. May cause vomiting. Chronic Health Effects: Prolonged or repeated contact may cause skin irritation. Signs/Symptoms: Overexposure may cause headaches and dizziness." "Wasp & Hornet Killer...Avoid contact with skin, eyes or clothing. Wash thoroughly with soap and water after handling."			

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	The most recent minimum data set (MDS) assessments for Residents #14, #20, #27 and #53 indicated they were cognitively impaired and independently ambulatory. All four of these residents resided in the front hallway in close proximity to the unattended cart. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to address a nurse practitioner (NP) progress note, regarding the addition of a nutritional supplement, and to provide an appetite stimulant as ordered, for 2 of 5 residents reviewed for nutrition.(Residents #5 and #13)	F 0325	F325 Based on a resident's comprehensive assessment, the facility does ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the	09/30/2016

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	Findings include: 1. The clinical record for Resident #5 was reviewed on 8/23/16 at 2:00 p.m. The diagnoses for Resident #5 included, but were not limited to: vascular dementia, depression, and diabetes mellitus type 2. The 7/29/16 NP progress note indicated Resident #5 had a past medical history of weight loss. It indicated, "Add 2 cal Med pass (nutritional supplement) tid (three times daily)." The July and August, 2016 physician's orders did not indicate an order for 2 cal Med pass. The July and August, 2016 medication administration records did not indicate 2 cal Med pass was given. An interview was conducted with QMA #5 on 8/31/16 at 3:00 p.m. She indicated she she could not remember ever administering Med pass to Resident #5. An interview was conducted with the DON (Director of Nursing) on 8/31/16 at 3:06 p.m. She indicated the facility received the NP and MD progress notes within 2 days of their visits, but they were usually just filed in the chart, and not reviewed.		resident's clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #5 is now receiving 2 cal Med Pass as previously recommended by the NP Resident #13 now receives Remeron as ordered by the physician. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents were at risk from this alleged deficient practice. A review was completed of all resident's charts to ensure no other orders from the PCP or NP have been missed. Deficient areas were corrected immediately. All orders in the resident's medical record were compared to their MAR/TAR to ensure accuracy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The RDCO in-serviced the DON on review of PCP and NP progress notes prior to filing in the medical record.	

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	An interview was conducted with the RDCO (Regional Director of Clinical Operations) on 8/31/16 at 3:13 p.m. She indicated she would expect nursing to look at the progress notes from the NP in case something was missed on the order. She indicated she thought nursing would have looked at the 7/29/16 progress note, saw the recommendation for Med pass tid, and clarified with the NP whether she wanted it or not. 2. The clinical record for Resident #13 was reviewed on 8/23/16 at 2:00 p.m. The diagnosis for Resident #13 included, but was not limited to: underweight. A "..YEARLY WEIGHT CHART.." indicated Resident #13's weight was 140 pounds in July and 131 pounds in August. A physician order dated 7/26/16, indicated the staff was to give 30 milligrams of remeron daily to Resident #13 for poor appetite. An August Medication Administration Record (MAR) was provided by the Director of Nursing on 8/30/16 at 12:04 p.m. It indicated the medication remeron was discontinued and a line drawn through the days and time the medication		The DON then in-serviced licensed nurses on the same. The in-service included receiving and transcribing orders promptly when received. The DON/Designee will keep a second copy of all PCP and NP progress notes when received and check daily until all recommendations/orders have been completed. **How the corrective action(s) 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 all physician's orders as necessary. The 24 hour sheets will be used to compare to the resident's medical record. MARs/TARs will be compared as well. Deficient areas will be corrected immediately. The DON/Designee will report findings to the Administrator who will report findings monthly to the facility QAA team who will determine the need/frequency of further monitoring after 6 months and/or if changes in monitoring need to occur based on results.	

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	was to be administered. There were no initials by staff indicating Resident #13 had received the medication from August 1st through August 30th. An interview was conducted with the Director of Nursing on 8/30/16 at 11:14 a.m. She reported the August MAR indicated the remeron was discontinued and Resident #13 had not received the medication in error. She stated Resident #13 should be administered 30 milligrams of remeron daily. An interview was conducted with Resident #13 on 8/30/16 at 11:41 a.m. He stated he had not received the remeron to increase his appetite in awhile. 3.1-46(a)(1)			
F 0353 SS=F Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.			

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	The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to provide sufficient nursing staff to provide nursing services to care for residents. This had the potential to affect 44 of 44 residents that reside in the facility. Findings include: 1. An interview was conducted with Resident #4 on 8/23/16 at 3:02 p.m. He indicated there is not enough CNAs (Certified Nursing Assistants) in the facility and he had to wait 45 minutes to receive dinner approximately two days ago. He further indicated this occurs often. An interview was conducted with Resident #38 on 8/23/16 at 2:56 p.m. He indicated the facility is short staffed all the time.	F 0353	F 353 SUFFICIENT 24 HOUR STAFF PER CARE PLAN It is the policy of the Lawrence Manor to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical mental and psychosocial wellbeing of each resident as determined by resident assessment and individual [plan of care. the resident exercises their right unless adjusted incompetent or otherwise found to be incapacitated under the laws of the state to participate in planning care and treatment or changes in treatment. Participate the facility to provide the resident with activities of daily living and necessary services to maintain good nutrition grooming and personal and oral hygiene. **Corrective Action Taken Related to this Finding** Lawrence Manor has hired an interim director of nursing to provide the leadership and direction	09/30/2016

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	An interview was conducted with Resident #13 on 8/23/16 at 12:02 p.m. He indicated first shift is always short. An interview was conducted with Resident #43 on 8/24/16 at 10:39 a.m. She indicated the facility is short staffed all the time. An interview was conducted with Resident #28 on 8/23/16 at 11:20 a.m. She indicated the facility is short staffed on all shifts and one night the facility went without having a CNA in the building. An interview was conducted with Resident #35 on 8/23/16 at 11:29 a.m. She indicated first shift is short resulting in a 10 minute delay in staff caring for her. An interview was conducted with Resident #34 on 8/23/16 at 2:17 p.m. She indicated all shifts are short staffed and there is never enough staff. She further indicated there is only two CNAs in the evening and only 1 CNA at night which resulted in a twenty minute wait time for assistance by staff. An interview was conducted with RN #8 on 8/25/16 at 11:58 a.m. She indicated		for the nursing department. The Lawrence Manor continues to advertise with the career builder's web site for nurses and certified nursing assistants. Lawrence Manor at present is also utilizing some contracted staffing services for the resident care services. Lawrence Manor addresses daily the staffing for each shift at the morning QA meeting. **I. Other Residents with Potential to be affected by this finding will be identified by:** All other residents at the Lawrence Manor have the potential to affect by this practice. **III. Measures and Systemic Changes put into Place to Assure /Deficit Practices do not recur are as Follows:** Lawrence Manor has set up the weekly scheduled orientation for new hires to the facility to ensure continuous staff in place to meet the resident's mental physical and psychosocial needs. Advance staffing needs are placed with contracted services for confirmation for fulfilling the staffing slots. The nursing staff is filling additional shifts to ensure resident staffing is complete. Staff patterns adjusted for the resident population to fulfill resident needs. Lawrence Manor has sufficient staffing for all three shifts. Completed staffing sheets and schedules review at the morning QA	

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	155721	A. BUILDING 00 B. WING	08/31/2016

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	the best staffing pattern for now, since the acuity is overwhelming, is to have two CNAs on the front hallway and 2 CNAs on the back hallway due to an increased census of residents. She further indicated there is not always two CNAs present to work so she will pull staff from restorative to compensate for the needed CNAs. The CNAs stay burnt out and the biggest concern is not having adequate staff here. RN #8 indicated this has been going on since she came to facility in May of 2016. An interview was conducted with LPN #5, from Nurse Staffing Agency, on 8/25/16 at 3:45 p.m. She indicated there is not sufficient staffing related to CNAs. On 8/25/16 there is only two CNAs working in the building and ideal would be to have 4 CNAs. She further indicated she works a few days a week and the facility always seems to be running short staffed when she works. An interview was conducted with CNA #10 on 8/31/16 at 4:17 p.m. She indicated the staffing has been bad during evening shift. Sometimes there is only one CNA that works for the entire building on evening shift. She further indicated she tries to complete her assignment with having 2 CNAs but sometimes it does not get completed. It is not fair to the		meeting. The Facility Resident Council host will review resident staffing thoughts/perspectives during each monthly resident council meeting and document concerns on the meeting minutes. **IV. Corrective Actions will be monitored to Ensure Compliance by:** The Administrator will observe the staffing schedule at QA meeting. The audit forms monitored weekly. Then for a period of three weeks, then monthly x 5 months. The Administrator will report findings to the QA committee monthly who will then decide on continued need and/or frequency of monitoring after 6 months. The Administrator will review monthly resident council meeting minutes on an on-going basis. If resident(s) express concerns with staffing, the Administrator and DON will meet to discuss voiced concerns and determine validity. The Administrator/DON will ensure staffing is adjusted to meet resident needs. The Administrator or DON will report findings to the QA committee monthly.	

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	residents or the staff for the difficult attempt to complete assignments and care for residents. She indicated there is only two CNAs working this evening. A document titled " Nursing Scheduale [sic] " was provided by the DON (Director of Nursing) on 8/23/16 at 11:45 a.m. The schedule indicated only two CNAs was scheduled to work on the following days for evening shift: 8/2/16 8/3/16 8/4/16 8/13/16 8/14/16 8/16/16 8/17/16 8/18/16 8/27/16 8/28/16 8/30/16 8/31/16 The Nursing Schedule indicated only one CNA was scheduled to work on the following days for night shift: 8/3/16 8/6/16 8/7/16 8/26/16			

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	A form titled " RESIDENT COUNCIL DEPARTMENTAL PLAN OF ACTION FORM " , dated 6/8/16, was provided by Regional Director of Operations (RDO) on 8/30/16 at 8:30 a.m. The form indicated the following, " Date: 6/8/16 ...Department Responsible: Nursing ...Concern/Grievance: Residents have to wait to [sic] long to get coffee. No one to pass it ...Action Taken ...Nursing is working on staffing @ [at] this time." A " Resident Council Form " , dated 8/26/16, was provided by the RDO on 8/30/16 at 8:30 a.m. The form indicated the following, " ...Nursing ...CNAs be more available ...short staffed ...." A document titled "Minutes" was provided by the Administrator on 8/31/16 at 6:35 p.m. The document indicated the following, "...Findings...PP [Performance Improvement In Progress]...1. Employee turnover...Employee Experience...Turnover, Staffing...P.P [Performance Improvement In Progress]...1. [Name of job staffing website]...2. [Name of job staffing website] Temporary Staffing Pool.... " 2. The clinical record for Resident #28 was reviewed on 8/23/16 at 10:30 a.m. The diagnoses for Resident #28 included, but were not limited to, neurogenic			

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	bladder and paraplegia. The indwelling foley catheter care plan, revised 8/10/16, indicated the goal was for Resident #28 to show no signs or symptoms of a urinary tract infection. It indicated, "Change foley catheter every month and prn (as needed) if not patent." It indicated, "Obtain orders for U/A (urinalysis) with C&S (culture and sensitivity) and labs as needed." The 8/26/16 Physician's Order for Resident #28 indicated, "Anchor new Foley catheter. Send U/A C&S in a.m. (morning) - fever, dysuria - take from new Foley." An interview was conducted with Resident #28 on 8/30/16 at 11:11 a.m. She indicated the nurse practitioner wrote an order to change her catheter and get a sample on Friday (8/26/16), and it still hadn't been done. She indicated, "I don't feel well. I think I have a UTI (urinary tract infection). I start to act different when I get a UTI, and I don't even realize it." An interview was conducted with RN #8 on 8/30/16 at 11:48 a.m. She indicated agency nursing staff was in the building over the weekend, and they did not change Resident #28's catheter, but took			

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	the urine specimen anyways, and sent it in, even though the order specifically said to take specimen from the new catheter. An interview was conducted with the DON on 8/30/16 at 11:56 a.m. She indicated she thought the facility only had one nurse capable of changing Resident #28's catheter. She indicated that particular nurse worked the previous evening, but she may not have known a new catheter needed placed. An interview was conducted with Resident #28 on 8/30/16 at 12:48 p.m. She stated, "This morning was the first time they tried to place a catheter." A policy titled "Staffing", revised April 2007, was provided by the RDO on 8/31/16 at 8:36 a.m. The policy indicated the following, "Policy Statement...Our facility provides adequate staffing to meet needed care and services for our resident population...1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services...2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined			

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	on the resident's comprehensive care plan...5. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee." 3.1-17(a)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure sanitization and water temperature levels were tested accurately on the dishwasher, per manufacture's instructions. This had a potential to affect 44 of 44 residents that eat food out of the kitchen. Findings include: An observation was made of the kitchen on 8/25/16 at 11:55 a.m., with the Dietary Consultant. The Dietary Consultant demonstrated the process of running the dishwasher. The temperature gauge that was located on the dishwasher did not move or reach 120 degrees Fahrenheit during the wash cycle. The Dietary Consultant placed a thermometer in the	F 0371	**F 371** food procure, store/prepare/serve-sanitary **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The temperature gage on the dishwasher is now replaced and working. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that deficient**	09/30/2016

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	side well of the dishwasher to test the water temperature during a wash cycle and was unable to get a temperature reading. During the sanitation rinse cycle, she stated the clear tube container that was located on the top of the dishwasher was the chlorine testing strips to confirm the water reached 50 ppm (parts per million) during the rinse cycle. After the Dietary Consultant dipped the test strip into the side well of the dishwasher the test strip was a slightly tinged purple shade. There was no color graph chart included in the container to compare the shade color of the test strip to confirm the rinse sanitation cycle reached 50 ppm. Dietary aid #6 and Dietary aid #7 stated there had been a color graph chart hanging on the wall next to the dishwasher, but they were unsure of what happened to it. There was no observation of a color graph chart on the wall. Dietary aid #6 and Dietary aid #7 indicated they had determined the dishwasher was reaching the 50 ppm by judging the strip color. If it was a light shade of purple it did not reach 50 ppm, and if the test strip turned a dark shade of purple it reached 50 ppm. Dietary aid #6 indicated the temperature gauge for the wash cycle had not been working for a few days. She stated the sanitation and soap chemicals were going through the tubing, and the dishes were coming out clean, so she had		**practice does not recur:** Dietary staff in serviced with signed attendance and training to ensure sanitation and water temperature levels are tested accurately on the dishwasher. The cook is responsible to monitor the temperature to ensure the temperatures are in the manufacture guidelines. If temperatures are not in the manufacture guidelines, the administrator is to be notified immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The dietary mgr/designee will perform audits of the temperature logs 5 days per week x 1 month, then 3 x per week x 1 month, then 2 x per week x 4 months to ensure 100% compliance. The consulting dietician will monitor the temperature logs at least 1 x per month. Results of the audits will be discussed during QA x 6 months.	

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	figured the dishes were ok. The Dietary Consultant indicated there had been repairs in the kitchen a few days prior, which might be the reason the dishwasher was not working at that time. The Dietary Consultant repositioned the soap and sanitation chemicals around on the floor and retested the sanitation rinse cycle 2 more times. The testing strips, both times, turned a light tinged color of purple after testing. Dietary Aide #6, Dietary Aide #7, and the Dietary Consultant could not confirm the dishes were properly sanitized during that time. An interview was conducted with the Dietary Consultant and Dishwasher Service Technician #9 on 8/25/16 at 1:15 p.m. Dishwasher Service Technician #9 indicated he had tested the water with a test strip, and the sanitization was reaching at or a little below 50 ppm. The dishwasher service tech #9 stated the water temperature did not have to reach 120 degrees Fahrenheit. The sanitation chemicals will work regardless of the water temperature. Dietary Consultant stated they had replaced the sanitation and soap chemicals. She indicated the containers were not completely empty but low. An interview was conducted with the Dietary Manager in the kitchen on			

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	8/25/16 at 1:28 p.m. She reported she tested the water temperatures herself by using a thermometer. At this time, she demonstrated by placing a thermometer in the side well of the dishwasher during the wash cycle. She indicated the water temperature was 117 degrees Fahrenheit at this time. She stated this morning she had tested the water temperature, and it had reached 118 degrees Fahrenheit. An interview was conducted with the dishwasher service tech #15 and the Dietary Consultant on 8/25/16 at 2:00 p.m. He reported the wash water temperatures on the dishwasher needed to be between 100-120 degrees Fahrenheit. He indicated the color graph chart was needed to compare the color shade on the chart with the test strip to confirm the sanitation of the water was reaching 50 ppm. The Dietary Consultant stated the chemical test strips used to test the sanitation in the kitchen earlier were expired. A phone interview was conducted with the dishwasher service tech #15 at 8/25/16 at 2:51 p.m. He indicated the dishwasher's owners manual that mentioned the water temperature needing to reach a minimum of 120 degrees Fahrenheit was referring to the the water temperature leaving the water heater			

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	through the pipes. The dishwasher service tech #15 stated he was unable to provide documentation that confirms the water temperature needs to be between 100-120 degrees Fahrenheit. He indicated the best place to confirm what the exact water temperature needed to be within the water temperature regulation would be the health department. The "..CHLORINE TEST PAPERS" label was provided by the Dietary Consultant on 8/25/16 at 2:07 p.m. It indicated, "...1. Immerse one inch of test strip in the solution. Remove immediately. Blot strip with paper towel. 2. Compare strip to color chart below..." A color graph was included with 4 different squares of shades of color from light to dark indicating on each shade what the ppm would be. The dishwasher owners manual was provided on 8/25/16 at 2:15 p.m. by the Dietary Consultant. It indicated "...OPERATOR PROCEDURES...5....If water temperature gauge has not reached 120 F (Fahrenheit) when the water level is just below overflow, drain water from the machine and continue to fill until proper temperature is attained...Chemicals..Sanitizer..The initial setting is 5 cc (cubic centimeters) and this should be checked regularly with			

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	a Chlorine Test kit. Free chlorine in the final rinse should be 50 ppm to 100 ppm...PREVENTATIVE MAINTENANCE...10. Test chlorine concentration using test paper. 50 ppm minimum.." A "FOOD & NUTRITION SERVICES DEPARTMENT PROCEDURE" was provided by the Dietary Consultant on 8/25/16 at 2:28 p.m. It indicated, "TITLE: Washing and Sanitizing Low Temperature of Dishmachine. STATEMENT OF PURPOSE: To describe how to verify the hot water temperature in the final rinse is 180 at the manifold. CONTENT: ...2. Dishwasher must be 100-120 degrees F (Fahrenheit) record. 3. Run chlorine strip through machine. 4. If strip turns dark in color (50-100 ppm) the dishmachine sanitizer is at correct..." 3.1-21(i)(1)(2)			
F 0412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL			

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Bldg. 00	SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview, and record review, the facility failed to provide dental services to 2 of 3 residents reviewed for dental. (Resident #14 and Resident #35) Findings include: 1. The clinical record for Resident #35 was reviewed on 8/23/16 at 2:30 p.m. The diagnoses for Resident #35 included, but were not limited to: bipolar disorder, depression, depressive disorder, and personality disorder. Resident #35's admission date was 7/19/16. A care plan dated 8/3/16, indicated Resident #35 "has oral/dental health problems r/t (related to) Teeth in poor condition with decay and poor oral hygiene hx (history)..." Interventions included but were not limited to: "...Schedule an initial dental consult with (name of dentist services) as soon as possible. Follow up as indicated..."	F 0412	**F 412 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident #14 was seen on 09/15/16 Resident #35 was seen on 08/29/16. All current resident were assessed for need of dental services. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** Upon admission nurses will complete admission assessment for need of dental services. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** DON will review the admission assessment and will sign off the assessment was completed and any appointments needed have been placed on the Scheduling sheet and given to social service to assist resident in	09/30/2016

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	The clinical record did not include an ancillary consent form for Resident #35. An interview was conducted with Resident #35 on 8/23/16 at 11:41 a.m. She stated she was missing 3 teeth and was interested in getting replacements. She indicated she had not seen the dentist. At that time, Resident #35 pointed out which teeth were missing. An interview was conducted with the Social Services Director (SSD) on 8/25/16 at 1: 00 p.m. She reported the dentist was last out on August 17th, and Resident #35 was not on the list. SSD stated she was not sure why Resident #35 was not seen and was going to check with Resident #35 about getting an ancillary consent. 2. The clinical record for Resident #14 was reviewed on 8/23/16 at 3:30 p.m. The diagnosis for Resident #14 included, but was not limited to: hemiplegia and hemiparesis following nontraumatic subarchnoid hemorrhage affecting right dominant side (stroke). Resident #14's admission date was 7/15/16. An Admission MDS (material data set) assessment dated 7/27/17, indicated Resident #14 had "broken or loosely fitted full or partial denture (chipped, cracked uncleanable or loose), ...Obvious or likely cavity or broken natural teeth.." A care plan dated 8/3/16, indicated Resident #14 "has a partial denture and a		setting up appointments **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** Social service will check the scheduling sheets weekly and assist resident with appointments. DON/designee will monitor for completion. Results will be discussed during QA monthly x 6 months.	

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	broken tooth, At risk for chewing problems.." Interventions included but was not limited to: "...Follow up with (name of dentist services) for an initial dental consult as soon as possible..." The clinical record did not include an ancillary consent form for Resident #14. An observation was made of Resident #14 on 8/23/16 at 2;07 p.m. Resident #14 was missing several teeth, and the few teeth that were seen were brown in color. At this time, Resident #14 reported she had dentures and was missing several teeth on the top and bottom. A "Scheduled Report Dentistry Visit" dated on 8/17/16, and a "Dentistry Visit" dated 8/26/16, was provided by SSD on 8/26/16 at 1:30 p.m. It indicated Resident #14 was not on either list in August to be seen. An interview was conducted with the SSD on 8/31/16 at 11:05 a.m. She indicated she could not locate an ancillary consent for Resident #14 and was unaware of the condition of her teeth. 3.1-24(a)(1)			

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F 0441 SS=F Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			

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	Based on observation, interview, and record review, the facility failed to ensure a resident's catheter tubing and collection bag remained off the floor and infection control practices were maintained during incontinent care and wound care for 1 of 1 residents reviewed for incontinent care, 1 of 1 residents observed with a catheter, and 1 of 3 residents reviewed for pressure ulcers. (Resident # 9, #16, and #32). The facility also failed to maintain an infection control log. This had the potential to affect 44 of 44 residents that reside at facility. Findings include: 1. During an observation, on 8/23/16 at 12:31 p.m., of the front dining room, Resident #32's urine collection bag and catheter tubing was noted to be laying on the floor. During the following observations, the bottom half of Resident #32's urine collection bag was noted to be laying on the floor: 8/25/16 at 8:58 a.m., 8/25/16 at 9:49 a.m., & 8/25/16 at 10:38 a.m. During an interview with the Regional	F 0441	F441 The facility does establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #32's urine collection bag and catheter tubing no longer lie or drag on the floor Resident #9 has infection control practices maintained during incontinent care Resident # 8 has infection control practices maintained during incontinent and wound care The infection control log has been implemented and is now kept up to date **How otherresidents having the potential to be affected by the same deficient practice willbe identified and what corrective action(s) will be taken?** This alleged deficient practice had the potential toaffect all residents. Staff now practice acceptable infection control for allresidents. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Nursing staff in-serviced by DON/Designee on acceptableinfection control practices with an emphasis on	09/30/2016

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	Director of Clinical Operations (RDCO), on 8/25/16 at 10:38 a.m., the RDCO observed the urine collection bag laying on the floor and indicated the urine collection bag should remain off of the floor due to infection control issues. A policy titled Urinary Catheters, dated 2009, was received from the RDCO, on 8/25/16 at 4:56 p.m. The policy indicated, "...VII. Keep the collection bag off the floor...." 2. During an observation of incontinent care for Resident #9, with CNA #2 and CNA #8 on 8/25/16 at 1:24 p.m., CNA #2 started pulling down Resident #9 brief with gloved hands. Green stool was noted on the brief. CNA #2 touched the bed control to lower the bed, and then CNA #2 pulled down Resident #9's brief the rest of the way. CNA #2 was not observed changing gloves prior to touching the bed control. CNA #2 was observed placing a moist towelette over Res colostomy bag that was leaking green stool. Incontinent care was provided by CNA #8 and a clean brief was pulled over Resident #9 feet. Resident #9 was rolled on to his back by CNA #2 and CNA #8. After Resident #9 was rolled to his back, CNA #2 pulled the brief the rest of the way up on Resident #9. CNA #2 was observed touching the bed control to		incontinent care, wound careand urinary collection bags/tubing. The RDCO/Designee/ADMIN reviewed the infection controllog with the DON and expectations for keeping the tracking log up to datemonthly. **How the correctiveaction(s) 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 select 3 residents per week x 4weeks, then 3 residents bi-weekly x 1 month, then 3 residents monthly for thenext 4 months to observe incontinence care and/or wound care to ensureappropriate infection control practices are maintained. Deficient areas will be addressedimmediately. The DON/Designee willreport findings monthly to the facility QAA team who will determine theneed/frequency of further monitoring after 6 months and/or if changes inmonitoring need to occur based on results. The Administrator/Designee will perform walking roundsdaily x 1 mo then a minimum of weekly thereafter, ongoing to ensure urinecollection bags are covered and bags and tubing are not dragging or lying on thefloor. Deficient practices will beaddressed immediately. The Administratorwill report findings monthly to the facility QAA team who will determine	

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	raise the bed, after the brief was pulled up. CNA #2 moved to the opposite side of the bed and was observed lifting Resident #9's oxygen mask over his head. CNA #2 was not observed changing her gloves or washing her hands after removing Resident #9's soiled brief, prior to touching the bed control or the Resident's oxygen mask. 3. During an observation of colostomy care with RN #8, on 8/25/16 at 1:34 p.m., RN #8 pulled off Resident #9's colostomy bag. Stool was observed on Resident #'9s skin. RN #8 was observed wiping Resident's skin with a washcloth and then a towel. RN#8 was observed handling a tube of colostomy paste to the new colostomy bag. RN #8 was not observed changing her gloves/washing her hands prior to touching the tube of colostomy paste. RN #8 applied the new colostomy bag and removed her gloves. During an interview with RN #8, on 8/25/16 at 1:44 p.m., RN #8 indicated she usually changed her gloves after wiping away stool from a Resident's skin prior to touching the colostomy paste tube. During an interview with the Regional Director of Clinical Operations (RDCO), on 8/25/16 at 4:35 p.m., she indicated gloves should be changed after contact		theneed/frequency of further monitoring after 6 months and/or if changes inmonitoring need to occur based on results. The RDCO/Designee will review the Infection ControlTracking log monthly times 6 months. Deficient areas will be corrected immediately. Findings will be reported to the Administratorwho will present monthly to the Facility QAA team who will determine theneed/frequency of further monitoring after 6 months and/or if changes inmonitoring need to occur based on results	

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	with brief before touching equipment. Additionally, staff should change gloves after providing colostomy care prior to touching the colostomy paste tube. A policy titled, Activities of Daily Living-Perineal Care, no date, was provided by the RDCO on 8/25/16 at 4:56 p.m. The policy indicated, "The purpose of this procedure are to provide the resident assistance with activities of daily living, provide cleanliness and comfort to the resident, to prevent infections...h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. i. Dry area thoroughly. 11. Discard disposable items into designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 13. Reposition the bed covers. Make the resident comfortable...." 4. During an observation of wound care with RN #8, on 8/30/16 at 11:20 a.m., RN #8 took Resident #16's wound dressing off from his right heel and placed his heel on top of his bed without a dressing in place. RN #8 then proceeded to clean Resident #16's wound with normal saline and reapplied Resident #16's heel back on top on the bed without a dressing in place. A red,			

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	baseball sized spot was noted on top of the blanket where Resident #16's heel was positioned on. RN #8 proceeded to apply treatment to the wound and wrapped Resident #16's wound with gauze. An interview was conducted with RN #8 at 8/30/16 at 11:35 a.m. She indicated it was not appropriate to have Resident #16's heel, without a dressing present, to be placed on top of a soiled sheet after being cleaned with normal saline. A policy titled " PREVENTION OF WOUND INFECTIONS " , revised in 2009, was provided by the Regional Director of Operations on 8/31/16 at 8:34 a.m. The policy indicated the following, "...II. DECUBITUS AND STASIS ULCERS ...A. Since chronic wounds are already highly contaminated with microorganisms, clean technique is used instead of sterile technique...." 5. The Infection Control Log, reviewed on 8/30/16 at 12:10 p.m., indicated no documentation for January, 2016 thru April, 2016. An interview was conducted with the Regional Director of Clinical Operations on 8/30/16 at 12:30 p.m. She indicated if the documentation is not located in the			

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	Infection Control Log then the facility does not have record of it. An interview was conducted with the DON (Director of Nursing) on 8/30/16 at 12:31 p.m. She indicated there is no further documentation to provide for January, 2016 thru April, 2016 of the Infection Control Log. A policy titled "INFECTION PREVENTION SURVEILLANCE", revised in 2009, was provided by the Regional Director of Clinical Operations on 8/31/16 at 8:34 a.m. The policy indicated the following, "...PURPOSE: To conduct surveillance of resident and employee infections to guide prevention activities ...II. Healthcare-associated infections are reported monthly on the: A. Healthcare-associated Infection Summary ...B. Summary of Infections by Device Days...." 3.1-18(a) 3.1-18(b)(1)			

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F 0502 SS=D Bldg. 00	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on observation, interview and record review, the facility failed to obtain a urinalysis (urine test) lab for 1 of 1 residents reviewed for labs. (Resident #18) Findings include: The clinical record for Resident #18 was reviewed on 8/31/16 at 3:30 p.m. The diagnosis for Resident #18 included, but was not limited to: dementia with behavioral disturbances. A physician order dated 8/10/16, indicated the staff was to obtain a urinalysis for Resident #18. An observation was made of Resident #18 on 8/23 at 3:54 p.m. Resident #18 was yelling out "help God". An observation was made of Resident #18 on 8/30/16 at 8:30 a.m. Resident #18 was in bed yelling out. An observation was made of Resident #18 on 8/30/16 at 1:00 p.m. Resident #18 was in hallway sitting in her	F 0502	F502 The facility does provide and obtain laboratory servicesto meet the needs of its residents. Thefacility is responsible for the quality and the timeliness of the services. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident #18s urine order was discontinued due to nosigns of infection per physician orders. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken?** Any resident with orders for lab work are at risk forthis alleged deficient practice. An audit was completed by DON/Designee of all resident lab orders. Any other identified, missedlab work was promptly re-scheduled for the next lab draw day or as soon as aspecimen was obtained (when required in the home). **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed Nurses have been in-serviced by the	09/30/2016

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	wheelchair yelling out. An observation was made of Resident #18 on 8/31/16 at 4:00 p.m. Resident #18 was in bed yelling out. An interview was conducted with the Director of Nursing (DON) on 8/31/16 at 4:53 p.m. She reported it was missed, and Resident #18's urine was not obtained for this lab. 3.1-49(a)		DON/Designee on ensuring completion of physician ordered laboratory work. The lab tracking binder will be checked daily for orders, obtained and results received along with the telephone orders. **How the correctiveaction(s) 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 select 5 resident charts per week x4 weeks, then 5 resident charts bi-weekly x 1 month, then 5 resident charts monthly for the next 4 months to ensure no further missing laboratory work. Deficient areas will be corrected immediately. The DON/Designee will report their findings monthly to the facility QAA team who will determine the need/frequency offurther monitoring after 6 months and/or if changes in monitoring need to occur based on results.	
F 0520 SS=F Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee			

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	consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to implement appropriate actions for the identification of abuse, protection from abuse, investigation of abuse, and the reporting of abuse in the facility. This had the potential to affect all 44 residents that reside in the facility. Findings include: On 8/23/16 at 12:30 p.m., the Administrator was made aware of 4 allegations of abuse. As of 8/25/16, the facility was found to	F 0520	F520 **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** QAA will meet and review abuse allegations since the previous meeting, including appropriate actions for identification of abuse, protection from abuse, investigations of abuse and the reporting of abuse, and previous month's abuse for trends of similar abuse and effectiveness of interventions.	09/30/2016

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	fail at implementing 4 out of 7 components of their abuse policy that included: reporting abuse, identifying abuse, investigating abuse, and protecting the residents' from abuse. On 8/24/16 at 2:41 p.m., a policy titled "Abuse & Neglect", revised on 9/1/14, was provided by the Administrator. The policy indicated the following, "...Identification...The staff will identify events, occurrences, patterns, and trends that may constitute abuse and to determine the direction of the investigation...Investigation...The facility will document the findings of the investigation on an investigation form developed by the facility...The documentation will include the identity of the staff member responsible for initial reporting, investigation of alleged violations, and reporting of results to the proper authorities...Protection...The facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified, that person will be suspended pending investigation...Reporting/Response...The facility will ensure that all alleged violations involving abuse are reported immediately to the administrator of the facility. Alleged violations will be reported to the appropriate state		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken"** All residents were at risk due to this alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Facility will hold a QAA committee meeting no less than quarterly. In addition to review of other identified areas of concern, the QAA team will review all abuse allegations that have occurred since the previous meeting to ensure all seven components required (including reporting, identifying, investigation and protection of residents) were met and properly addressed. Education and/or disciplinary action will follow with any deficient are noted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The RDO or RDCO will attend at least	

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	agency...The facility will analyze the occurrence to determine whether any changes are needed to policies and procedures to prevent further occurrence." A document titled "Minutes", undated, was provided by the Administrator on 8/31/16 at 6:35 p.m. The document indicated a potential concern that was a "Performance Improvement in Progress" that showed abuse training dated 7/8/16. An interview was conducted with the Administrator on 8/31/16 at 6:13 p.m. He indicated the facility's QA&A (Quality Assessment & Assurance) committee did not address concerns from the survey that were discussed at the previous QA&A meeting. He stated that he had only attended one QA&A meeting since he had been at the facility. The Employee Records form indicated the Administrator's start date was 6/15/16. An interview was conducted with Consultant #9 on 8/31/16 at 6:17 p.m. She indicated she comes to the facility and conducts audits that identify potential concerns for the facility to address and sends a report to the administrator to follow-up with. She further indicated		2 QAA meetings during the next 6 months and review findings of the abuse allegation reviews and ensure that education and/or disciplinary action were administered if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	these concerns could be addressed in QA&A but was unaware if the concerns were discussed or have been addressed. 3.1-52(b)(2)			