STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00221747. Complaint IN00221747-Substantiated. Federal/State deficiencies related to the allegations are cited at F242, F312 and F329. Survey dates: February 20, 21, 22, 23, 24, 27 and 28, 2017 Facility number: 001149 Provider number: 155618 AIM number: 200145500 Census bed type: SNF: 14 SNF/NF: 28 Residential: 79 Total: 121 Census payor type: Medicare: 6 Medicaid: 28 Other: 8 Total: 42 Sample: 7	F 0000		

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

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 3, 2017.			
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Based on observation, interview and record review, the facility failed to ensure a resident's preference for getting up was followed for 1 of 2 residents being reviewed for choices (Resident B). Finding includes: During an interview on 2/22/17 at 3:29 p.m., Resident B's significant other indicated the resident was supposed to be up by 11:00 a.m. He indicated he had to	F 0242	The statement made in this plan of correction is not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of	03/30/2017

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	get her up at times, when he came to see her in the afternoons between 2:30 p.m. and 5:00 p.m., because she was still in the bed. Resident B's record was reviewed on 2/27/17 at 9:22 a.m. Diagnoses included, but were not limited to, cerebrovascular accident, hypertension, G (Gastrostomy) -tube feed, dysphagia (trouble swallowing) and left sided parathesia (pins and needles sensation). The "CNA Task Description Plan of Care" dated 2/8/17, indicated the resident was to be up by 11:00 a.m., daily. ADL (Activities of Daily Living) indicated assist with two persons with total level of assist. (FYI) (For Your Information) the resident was dependent for transfers by the Hoyer lift. During an interview 2/27/17 at 9:35 a.m., CNA #1 indicated the resident's significant other had requested the resident be up everyday. She indicated she got the resident up everyday when she had her and brought her out to the living room to watch TV, then the Activities Director took her to activities. She put her back to bed and changed her brief after lunch and got her back up. On 2/27/17 at 11:15 a.m., CNA #1 was		compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. **Corrective actions accomplished for resident found to be affected by this alleged practice** Resident B is to be up at her preferred time as indicated by her guardian. **Other residents having the potential to be affected by this alleged deficient practice** Residents and /or responsible parties have been interviewed regarding their preferred get up time. Residents are now getting up at their preferred time as indicated on their care plan. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff have been in-serviced /educated by the Director of Nursing/ Designee regarding the importance of following resident's care plans related to their choice for preferred get up time. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur**	

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	observed giving the resident a bed bath. CNA #1 indicated she would get the resident up at 11:30 a.m., because she had two other residents she needed to lay back down and change for incontinence prior to getting this resident up. On 2/27/17 at 12:56 p.m., the resident was transferred to her wheelchair by CNA #1 and LPN #2, then transported to the living room to watch TV by CNA #1. During an interview on 2/27/17 at 2:45 p.m., the SSD (Social Service Director) indicated the resident's significant other was at the facility daily to visit her in the afternoon. He was very involved in her care and wanted what was best for her. This Federal tag relates to Complaint IN00221747. 3.1-3 (u)(1)		The Director of Nursing / Designee will monitor residents who have designated a preferred get up time to ensure compliance. This monitoring will be completed three times a week times four weeks. Any corrections needed will be addressed immediately. This monitoring will be taken to monthly QA&A for review / recommendations. **What quality assurance program will be put into place** Monitoring will be reviewed monthly in QA&A. Identified deficiencies will be corrected immediately and maintained as part of QA&A until there is substantial compliance	
F 0312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT			

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Bldg. 00	RESIDENTS (a)(2) 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 ensure a resident totally dependent for ADL's (Activities of Daily Living) was transferred out of bed into his chair on a daily basis for 1 of 3 residents reviewed for ADL's (Resident C). Finding includes: During an interview on 2/23/17 at 10:41 a.m., Resident C's family member indicated the staff were placing him in his chair daily, but they do not do that any longer, even though she has asked them to get him out of the bed. The following observations of Resident C were made on the following dates and times: On 2/23/17 at 2:45 p.m., he was laying in bed on his back. On 2/24/17 at 8:09 a.m., he was laying in bed on his back with his eyes closed. During an interview on 2/24/17 at 8:43 a.m., the Second Floor Unit Manager indicated "sometimes" the staff got him	F 0312	**Corrective actions accomplished for resident found to be affected by this alleged deficient practice** - Resident C is transferred out of bed into his chair once a week per guardian's request made during an interview with Director of nursing 3/07/17. **Other residents having the potential to be affected by this alleged deficient practice** All other totally dependent residents have the potential to be affected. **Measures put into place /systemic changes made to ensure the alleged deficient practice does not recur** Nursing staff has been in-serviced/re-educated by the Director of Nursing/ Designee regarding the importance of following the resident's care plan related to transferring totally dependent residents out of bed and into their chair per the resident's/family's choice/care plan. The Director of Nursing /Designee	03/30/2017

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	up in the chair. He was unaware of Resident C's family member wanting him to get up every morning. On 2/24/17 at 9:01 a.m., he was laying in bed on his back. On 2/24/17 at 10:01 a.m., he was laying in bed on his left side. On 2/24/17 at 12:09 p.m., he was laying in bed on his right side. On 2/24/17 at 2:21 p.m., he was laying in bed on his back. On 2/24/17 at 8:02 a.m., he was laying in bed on his back. On 2/24/17 at 9:03 a.m., he was laying in bed on his left side. During an interview on 2/27/17 at 10:22 a.m., with CNA #3 and the Second Floor Unit Manager in attendance, CNA #3 indicated she had "never" gotten Resident C out of bed into his chair. At that time, the Second Floor Unit Manager indicated the resident "usually" remained in the bed and was "only" gotten up one time a week. He indicated he unaware his family member wanted him out of bed more often than once a week.		will monitor residents who are totally dependent for ADL's to ensure they are transferred out of bed and into their chair as their care plan indicates. **How the corrective action will be monitored to ensure the alleged deficient practice does not recur** This monitoring will be completed five times four weeks; then three times weekly times four weeks. Any deficiencies will be addressed immediately. This monitoring will be taken to QA&A for review /recommendations. **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:** This monitoring will be taken to monthly QA&A for review/ recommendations monthly.	

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	On 2/27/17 at 11:00 a.m., he was laying on his right side During an interview on 2/27/17 at 3:40 p.m., the Second Floor Unit Manager indicated he encouraged the CNA's to get Resident C out of bed into his chair, but he did not know why the staff did not get him out of bed everyday. On 2/27/17 at 3:47 p.m., he was laying in bed on his left side. On 2/28/17 at 8:56 a.m., he was laying in bed on his right side. Resident C's record was revived on 2/27/17 at 9:11 a.m. Diagnoses included, but were not limited to, anoxic brain damage, contractures of the left elbow and bilateral hands and right elbow, and persistent vegetative state. A significant change MDS (Minimum Data Set) assessment dated 10/13/16, indicated the functional status for ADL's indicated the transfer ADL was an 8/8, which indicated it did not occur during the seven day look back period for that assessment. A quarterly MDS assessment dated 1/9/17, indicated the functional status for ADL's indicated the transfer ADL was an			

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	8/8, which indicated it did not occur during the seven day look back period for that assessment. This Federal tag relates to Complaint IN00221747. 3.1-38(a)(2)(B)			
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to follow pressure ulcer interventions to prevent the development of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident 48).	F 0314	**Corrective action accomplished for resident found to be affected by this alleged deficient practice** Resident # 48 has interventions to prevent the development of pressures ulcers. Interventions have	03/30/2017

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	Finding includes: On 2/23/17 at 2:24 p.m., Resident 48 was observed in the common area sitting in his broda chair. During an interview on 2/23/17 at 2:26 p.m., the Second Floor Unit Manager indicated wound rounds were done that day by the wound doctor. He indicated Resident 48's stage III pressure wound was healed. The treatment ordered was barrier cream applied with incontinent care and prophylactic skin interventions. On 2/24/17 from 9:13 a.m. to 10:03 a.m., a continuous observation was completed of Resident 48. He was observed sitting in his broda chair in the dining room. He was not checked for incontinence during that time, and a strong odor was noted around the resident. On 02/24/2017 at 10:16 a.m., CNA #4 and CNA #5 were observed performing peri-care on the resident, but no barrier cream was applied as ordered by the physician. The resident's skin was red and excoriated on his buttocks and peri-area. The resident was positioned on his back, with pressure remaining on his buttocks. Pillows were not used to position the		been reviewed and updated as needed andare being followed. **Other residents having the potential to be affected by this alleged deficient practice:** Residents who are at risk for developing pressure ulcers have the potential to be affected. Care plans are being followed for residents whose care plans indicate interventions to prevent the development of pressure ulcers. **Measures put into place/ systemic changes made to ensure the alleged deficient practice does not recur :** Nursing staff has been in-serviced /re -educated regarding following care plan interventions related to prevention of the development of pressure ulcers. **How the corrective action will be monitored to ensure the alleged deficient practice does not recur :** The Director of Nursing /Designee will monitor that residents' care plans have interventions related to the prevention of the development of pressure ulcers and that interventions are followed. This monitoring will be completed five times a week times four weeks. Then three times weekly times for four weeks. Any needed corrections will addressed immediately. This	

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	resident to off-load pressure from his buttocks, as was required according to his care plan. On 2/24/17 at 3:32 p.m., the resident was observed sitting in his broda chair in the common area and pressure remained on his buttocks. On 2/24/17 at 3:39 p.m., CNA #4 and CNA #5 were observed performing peri-care for Resident 48. The resident's buttocks and peri-area were red and excoriated and no barrier cream was applied after incontinent care was given. The resident was positioned in bed on his back and no pillows were used for positioning and there was no off-loading of pressure from his buttocks. During an interview on 2/24/17 at 3:45 p.m., with CNA #4 and CNA #5 in attendance. CNA #4 indicated they sometimes alert a nurse when they do peri-care to apply the barrier cream. CNA #5 was asked to inform a nurse the barrier cream needed applied after they had finished providing incontinent care for the resident. When CNA #5 returned to the resident's room, she indicated she asked two nurses and both were unavailable to apply the barrier cream at that time.		monitoring will be taken to monthly QA&A for review /recommendations. **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:** This monitoring will be taken to monthly QA&A for review/ recommendations monthly	

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	On 2/27/17 at 8:42 a.m., the resident was observed in the dining room finishing his breakfast. He was sitting in his broda chair with the Hoyer lift sling under his buttocks. On 2/27/17 at 10:06 a.m., Resident 48 was observed sitting in the common area in his broda chair with the Hoyer sling under his buttocks. On 2/27/17 at 12:33 p.m., the resident was observed sitting in his broda chair in his room in the same position he had been in since breakfast, with the Hoyer sling under his buttocks. Resident 48's record review was completed on 02/23/2017 at 3:31 p.m. Diagnosis included, but were not limited to, dementia, muscle weakness and a history of falls. A Physician's order dated 01/27/2016, for offloading pressure from coccyx and sacrum when able. A Care plan dated 09/09/2016, entitled, "Stage III Non-Healing Pressure Ulcer to Coccyx related to impaired mobility." Interventions included, but were not limited to, "....Administer treatment per physician's orders, assist with turning and repositioning....use pillows and			

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	positioning devices as needed." A Wound Physician progress note indicated, "...healing stage III pressure has resolved....treat prophylactically with barrier cream...use pressure reducing cushion in chair...." 3.1-40(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.			

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	(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview and record review, the facility failed to follow fall prevention interventions to maintain an environment free from accidents for 1 of 3 residents observed for accidents (Resident 48). Finding includes: On 2/24/17 at 10:16 a.m., CNA #4 and CNA #5 were observed taking Resident 48 to his room. He was transferred without the use of a gait belt. The CNA's lifted the resident from under his arms and grabbed the back of his pants and transferred him from his broda chair to his bed. Resident 48 was positioned on his back, without pillows used for positioning. CNA #4 did not place a floor mat on both sides of the bed. On 2/24/17 at 3:39 p.m., CNA #4 and CNA #5 were observed assisting the resident to bed. A gait belt was not used during the transfer. The CNA's lifted the resident	F 0323	**Corrective action accomplished for resident found to be affected by this alleged practice :** Resident #48 has care planned interventions which have been reviewed and updated as needed to maintain an environment free from accidents. These interventions are being followed for this resident. **Other residents having the potential to be affected by this alleged deficient practice :** Residents who have fall mats as fall interventions have the potential to be affected. Care plans are being followed for residents whose care plans fall mats as interventions **Measures put into place /systemic changes made to ensure the alleged deficient practice does not recur** Nursing staff has been in-serviced / re-educated regarding following care plan interventions related to maintaining an environment free from falls **How the corrective action will be**	03/30/2017

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	under his arms and grabbed the back of his pants, then transferred him from his chair to his bed. During an interview on 2/24/17 at 3:45 p.m., CNA #4 indicated she used a gait belt for a resident who used a walker. If a resident had a history of falls, she would use a gait belt or a lift to transfer the resident. During an interview on 2/27/17 at 10:25 a.m., the Interim Director of Nursing (DON) indicated gait belts were used when CNA's deemed the use of a gait belt was necessary to complete a safe transfer. Resident 48's record review was completed on 2/23/17 at 3:31 p.m. Diagnosis included, but were not limited to, dementia, muscle weakness and a history of falls. Resident 48 had a care plan dated 9/16/16, entitled, "At risk for falls related to dementia, muscle weakness, poor safety awareness, and potential medication side effects." The care plan interventions included, but were not limited to, "...safety mat to both sides of the bed...." 3.1-45(a)(2)		**monitored to ensure the alleged deficient practice does not recur** The Director of Nursing / Designee will monitor that residents' care plans whose care plans include fall mats have interventions in place. This monitoring will be completed five times a week times four weeks; then three times weekly times four weeks. Any needed corrections will be made immediately. This monitoring will be taken to monthly QA&A. **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:** This monitoring will be taken to monthly QA&A for review/ recommendations monthly	

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	155618	A. BUILDING 00 B. WING	02/28/2017

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F 0325 SS=D Bldg. 00	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to ensure weight loss prevention intervention recommendations were implemented and followed for 1 of 3 residents reviewed for nutrition (Resident G). Findings include: On 2/24/17 at 8:51 a.m., Resident G was observed in the Second floor dining room feeding himself breakfast with a built-up	F 0325	It is the practice of this facility to comply with F325 and maintain acceptable parameters of nutritional status and offer a therapeutic diet as ordered. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Required assistive devices as recommended by the registered dietitian in place for resident G the day of survey 2/24/2017. The Dietary service manager has	03/30/2017

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	spoon. He had scrambled eggs and biscuits and gravy in two of the three compartments of a divided plate and oatmeal in a small gray cereal bowl. He had orange juice in a small sized white container, milk and water in a medium sized white plastic glass and a hot liquid in a handled cup with a lid and a straw. He had a regular knife, fork and spoon, which was wrapped in his napkin. As the resident would try to use his built-up spoon to dip into the bowl with the oatmeal, the bowl scooted on the table in front of him making it difficult for him to get oatmeal onto his spoon. He unwrapped his regular silverware from the napkin and took the fork attempted to dip it into the oatmeal to get a bite. The bowl with the oatmeal continued to scoot in front of him making it difficult for him to eat it. The Interim DON (Director of Nursing) at that time, placed the oatmeal from the gray bowl into the empty portion of the third compartment of the divided plate. During that time, the Interim DON asked the resident for the fork and gave him his built-up spoon and instructed him to eat with his built-up spoon. On 2/24/17 at 8:56 a.m., the Interim DON assisted the resident with his breakfast.		reviewed the registered dietitian recommendations and the utensils are in place as ordered who require such. Licensed Nurses and CNA's in-service 3/14/2016 regarding checking the meal ticket to check that the recommended utensil are present prior to the meal being served. The IDT to meet weekly to review Registered Dietician recommendations and monitor weight fluctuations . The physician will be notified of negative weight changes and the IDT will follow the recommendations of the registered dietician and physician As part the weight management team the use of therapeutic utensils will be reviewed to ensure that the appropriate utensils recommended by therapy are in place and documented on the meal ticket. **Other residents having the potential to be affected by this alleged deficient practice :** All residents requiring assistive devices for meal consumption have the potential to be affected. There are eight residents who currently utilize assistive devices. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The dietary service manager has put into place a dietary utensil audit tool to verify that the appropriate therapeutic utensils are on the	

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	Resident G's breakfast meal ticket indicated he was to eat a mechanical soft diet. The adaptive equipment he was supposed to have was a plate guard, divided plate, built-up fork, built-up spoon and cup with a lid. The special instruction listed was: "Plate Guard every meal." The extra item listed was "Plate Guard." The resident's three compartment divided plate did not have a plate guard on it and he did not have a built-up fork. During an interview on 2/24/17 at 9:20 a.m., the Interim DON indicated the resident was to have a built-up fork and a plate guard on his divided plate and those items should have been placed on his plate and tray when his food was being "dished up" by the cook. During an interview on 2/24/17 at 9:43 a.m., the Second floor Unit Manager indicated he had spoken to the kitchen staff, who served the breakfast food on the Second floor that morning and he indicated he was told by the kitchen servers, they was "short" on plate guards. During an interview on 2/24/17 at 10:40 a.m., the Food Service Director (FSD) indicated the kitchen was not "short" on plate guards, the food servers could not		resident's tray or at their table setting at meal service. Meals trays to be monitored daily for 2 weeks, 3x a week for 2 weeks, and 2x weekly for 2 months. The IDT will meet weekly to review registered Dietician's recommendation and monitor weight fluctuation. The physician will be notified of negative weight changes and the IDT will follow the recommendations of the registered dietician and physician. As part the weight management team , the use of therapeutic utensils will be reviewed to insure that the appropriate utensils recommended by therapy are in place and documented on meal ticket. This weight loss committee will be ongoing from this point forward. **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:** Meals trays to be monitored daily for 2 weeks, 3x a week for 2 weeks, and 2x weekly for 2 months. The monitoring will be reviewed monthly by the QA&A committee. The IDT team as part of the Quality measures review will discuss any residents identified as significant weight as identified on the MDS and make recommendation as deemed appropriate. The review of this QM will be done monthly.	

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	locate the plate guards, but they have all of them now. During an interview on 2/24/17 at 11:19 a.m., the FSD indicated the kitchen was "short" one plate guard and she tried to obtain one from pharmacies, the hospital and other facilities and no place had one she could buy or use, so she had to order another one. She indicated she would be "short" a plate guard until she received another one. The kitchen staff did not communicate with her they were "short" on plate guards prior to this date. During an interview on 2/24/17 at 12:04 p.m., the FSD indicated she found the other plate guard, so they were not "short" a plate guard. Resident G's record was reviewed on 2/24/17 at 12:34 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, dysphagia, and major depressive disorder, The resident had a Care plan dated 10/9/16, which addressed the problem nutritional status as evidenced by potential weight loss related to modified textures and adaptive equipment due to a medical diagnosis of significant weight loss for 30 days. Interventions included, but were not limited to, "10/9/16--divided		**By what date will the systemic changes be completed:** March 30, 2017	

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	plate; lidded cup with long straw...." Resident G's Order Summary Report dated February 2017, included, but was not limited to, the following order: 11/22/16--Mechanical Soft Texture, House supplement every day. The resident's weights for the following dates were: 10/9/16--158 10/13/16--160 10/16/16--159 10/23/16--163 10/30/16--142 12/21/16--160 1/1/17--160 1/2/17--164 2/4/17--152 2/23/17--152 A Nutrition/Weight progress note dated 10/20/16 at 1:13 p.m., indicated "Nutrition/Weight: Admission Nutrition/RD [Registered Dietician] Note Ht: [height] 64" Wt: [weight] 159# [pounds]... IBW: [ideal body weight] =130#... ABW [average body weight] =137#... BMI [body mass index]=27.4 (Overwt) [overweight] wife usually takes foods to room in take-out containers that resemble divided plates: natural teeth that work 'ok" SP [Speech Therapy] feels mech [mechanical] soft diet works for			

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	this resident for chewing/swallowing needs at this time...Current intake of Mech Soft diet meets needs & may allow wt gain... Plan:..do not recommend adding/using Ensure products as they will add more Kcal [kilocalories] than needed, Await OT [Occupational Therapy] finding to ensure tray ticket is updated to enable resident to easily eat meals, maintain current wt w [with]/meals, not supplements...." A General Progress Note dated 11/6/16 at 12:42 p.m., indicated "Late Entry: 30 day Review: Diet Reg [Regular]/MS [mechanical soft]...Exhibiting a 16.2# (10.2%) wt loss x [times] 30 days, wt loss sign [significant]...Suggest house supplement QD [everyday] to aid with weight maintenance...." A Nutrition/Weight progress note dated 12/1/16 at 11:04 a.m., indicated "Nutrition/Weight: 60 day Review: Dx [diagnoses] Parkinsons, Dysphagia, depression...patient receives house supplement QD... Exhibiting a 16.2# (10.2%) wt loss x 30 days, wt loss sig...Suggest house supplement TID between meals to aid with weight maintenance...." During an interview on 2/28/17 at 4:33 p.m., the Registered Dietician (RD)			

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	indicated she could not locate the order indicated the resident was to receive a house supplement three times a day on the December 2016 through the February 2017, Medication Administration Records or the Treatment Administration Records. Recommendations for changes in Nutrition were communicated to nursing with a "Nursing Daily Interdisciplinary Eagle Room Report," which was given to the Director of Nursing (DON) before she left the facility each day after her visit. She determined who the residents were she visited the days she came to the facility by looking at the monthly weights she received from the facility. She based her resident visits on the monthly weights and if the resident had gained or lost weight. If the resident gained or lost weight, then she would followup with that resident accordingly. If Resident 64 had not lost anymore weight, then she wound not have followed up on him for weight loss. During an interview on 2/28/17 at 4:10 p.m., the Interim DON indicated the RD gave her the "Daily Interdisciplinary Eagle Room Report" and the RD wrote her recommendations as orders prior to her leaving the facility for that day's visit, so that was why the Nursing staff had not written the order for the Supplement for this resident from 12/1/16. She indicated			

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	the process for the RD writing an order would follow these steps: The RD wrote the order from her recommendations, then she flagged the order in the chart for the nurse to see there was a new order. The nurse took the order off and the order was placed in the doctors book. During an interview on 2/28/17 at 5:00 p.m., the RD indicated when she gave the "Daily Interdisciplinary Eagle Room Report" to the DON, she had already written her orders for her recommendations. During an interview on 2/28/17 at 6:10 p.m., the Interim DON indicated Resident 64 received his house supplement in the evening as his bedtime snack. He did not receive the supplement any other time during the day. A current policy titled "Weight Management Process Flowchart" undated provided by the Interim DON on 2/28/17 at 5:17 p.m., indicated "Assess...Does patient have a weight loss... Yes...Contact registered dietician and other disciplines as needed...Develop/Revise Initial or Interdisciplinary Care Plan as applicable with RD. Implement. Weight Management Strategies...."			

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	3.1-46(a)(1)			
F 0329 SS=D Bldg. 00	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to adequately monitor side effects of an antipsychotic medication (Resident D) and lacked an accurate diagnosis for an antidepressant medication (Resident G) for 2 of 5 residents reviewed for unnecessary medications. Findings include:	F 0329	It is the practice of this facility to comply with F329 by adequately monitoring side effects of an antipsychotic medication and accurate diagnosis for an antidepressant medication. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents D has the AIMS completed on March 1, 2017	03/30/2017

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	1. Resident D's record was reviewed on 2/27/17 at 4:35 p.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, dysphagia, and vascular disease with behavioral disturbance. A physician order dated 1/19/17, indicated Zyprexa (an antipsychotic medication) 10 mg (milligrams)give one tablet by mouth at bedtime for bipolar disorder. The resident had a Care Plan dated 2/28/16, which addressed the problem at risk for adverse effects related to use of an antipsychotic medication and use of an antianxiety/anxiolytic medication. Interventions included, but were not limited to, "2/28/16--Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs (i.e., AIMS [Abnormal Involuntary Movement Scale] [A rating scale used to detect and follow the severity of involuntary movements known as Tardive Dyskinesia, which developed as a side effect of long-term treatment with antipsychotic medications]...etc)... 2/28/16--Report to physician signs of adverse reaction such as decline in mental status,decline in		Resident G had the diagnosis for Fluoxetine corrected on February 27,2017 Other residents having the potential to be affected by this alleged deficient practice : Residents receiving psychoactive medications have the potential to be affected. All residents requiring the use of psychoactive medications were review for appropriate indication and diagnosis. All deficiencies were corrected. All residents requiring the use of antipsychotic medications were reviewed and AIMS completed as indicated. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Social Worker, Director of Nursing, Pharmacy will review residents with psychoactive medication monthly to validate correct diagnosis and monitoring of side effects of residents with antipsychotic medications. All current residents with psychoactive medications were audited for observance of the presence or absence of psychoactive medication side effects. AIMS were completed for these residents and are scheduled to be completed every 6 months. All new admissions and new orders will be reviewed and any residents with psychoactive medications will be reviewed monthly at the behavior committee	

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	positioning/ambulation ability, lethargy, complaints of dizziness, tremors, etc." Resident D's record lacked AIMS testing for side effect monitoring for Tardive Dyskinesia (Involuntary movements of the tongue, lips, face, trunk and extremities, which occur in residents treated with long term use of antipsychotics.) During an interview on 2/28/17 at 5:30 p.m., the Interim Executive Director indicated she was unable to find an AIMS assessment in the resident's record. She indicated the AIMS assessment was completed for the first time as far as she knew on 2/28/17 and the resident should have had an AIMS assessment done prior to this one. The Nursing Drug Handbook 2014, indicated "...Monitor patient for tardive dyskinesia, which may occur after prolonged use. It may not appear until months or years later and may disappear spontaneously or persist for life, despite stopping drug...." 2. Resident G's record was reviewed on 2/24/17 at 12:34 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety disorders, dysphagia and major depressive disorder.		meeting to validate that all medications have appropriate diagnosis. All new residents admitted with medications requiring side effect monitoring will have an AIMS completed and will be scheduled for an AIMS review every 6 months. 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: An unnecessary medication audit will be completed monthly and results reported to QA&A. All deficiencies will be immediately corrected. The QAPI team will review the results monthly for 3 months and ongoing if deemed necessary. By what date will the systemic changes be completed: March 30, 2017	

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A physicians order dated 10/12/16, indicated the indication for Prozac (Fluoxetine Hydrochloride) (an antidepressant medication) and Buspirone (an antianxiety medication) was for chronic anxiety.

A physicians order dated 10/13/16, indicated Fluoxetine Hydrochloride 20 mg (milligrams) give one capsule by mouth one time a day for chronic anxiety.

A progress note dated 1/2/17 at 9:32 a.m., indicated "Fluoxetine HCL [Hydrochloride] Capsule 20 mg Give 1 capsule by mouth one time a day for chronic anxiety on order no adverse effects noted."

During an interview on 2/27/16 at 9:56 a.m., the Social Services Director indicated on 10/13/16, the resident's Fluoxetine HCL medication diagnosis was changed to anxiety. She indicated anxiety was an incorrect diagnosis for his Fluoxetine HCL because it was supposed to be depression and she did not know why the diagnosis was changed to anxiety.

This Federal tag relates to Complaint IN00221747.

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	3.1-48(a)(3) 3.1-48(a)(4)			
F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to maintain floors and walls, cover 1 of 4 garbage cans, dry clean pans, and discard	F 0371	It is the practice of this facility to comply with F 371 by maintaining a sanitary kitchen environment and the safe storage, preparation,	03/30/2017

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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
	2 dented cans in 1 of 1 kitchen observations. This deficient practice had the potential to affect 39 of the 42 residents being served food from the kitchen. Findings include: The kitchen tour was completed on 02/20/2017 at 12:40 p.m., with the Director of Food Services (DFS) and the Kitchen Manager in attendance. 1. The dry storage area was observed to have the following: One large dented can of Cranberried Jelly One large dented can of Cream of Chicken Soup During an interview with the DFS on 02/20/2017 at 12:50 p.m., she indicated it was the facility's policy to return dented cans to the distributor. 2. The clean pan storage area was observed to have 50 pans with clear liquid on them. The liquid ran down the sides of the stacked pans as they were moved. One stacked pan had clear liquid pooled in the lip edge of pan. During an interview with the DFS on		procurement, and service of food. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: The Dietary staff have been in-serviced on February 20, 2017 for handling of dented cans, appropriate drying of dishes. The facility contracted for the re-grouting of the kitchen floor. This was completed on 03/17/17 The walls have been cleaned, sanitized and repainted by a contractor effective 3/17/17 New garbage pans with self-closing lids have been purchased and in place effective 2/28/2016 Other residents having the potential to be affected by this alleged deficient practice : All residents have the potential to be affected. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Dietary Manager will conduct daily sanitation rounds to observe for dented cans, the drying of dishes, cleanliness of the floor grout, kitchen walls, and garbage cans for lids. Rounds will be completed daily (Monday-Friday) for two weeks, three times a week for two weeks, weekly for four weeks and monthly thereafter.	

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	02/20/2017 at 12:55 p.m., she indicated it was the facility's policy to allow the pans to dry before being placed in the clean storage area. She indicated the dishwashers were aware of the policy. A current policy titled "Cleaning Procedure - Pots and Pans" dated September 2014, was provided by the Director of Food Services on 2/20/17 at 2:17 p.m. "...Remove pans from sanitizing sink. Invert to drain. Air dry. Pans may be stacked once pan is completely dry...." 3. The kitchen floor was observed to have grout eroding. Debris remained trapped between tiles where the grout was eroded, after the floor was swept. In the dishwashing area the grout eroded, causing some tiles to be loose. During an interview with the DFS on 02/20/2017 at 1:00 p.m., she indicated it was difficult to maintain the floors with the grout eroded. She indicated she submitted a work order to have the missing grout repaired in the kitchen floors, to date the work had not been done. 4. The walls surrounding the sinks in the dishwashing area were observed to have a black substance in a splatter pattern.		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: Sanitary rounds will be reviewed in QA&A monthly. Identified deficiencies will be reviewed and corrected immediately. QA&A will continue to observe until deficiencies are no longer identified. By what date will the systemic changes be completed: March 30, 2017	

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	The black substance was also observed on the walls under the automatic dishwasher and under the garbage disposal sink. During an interview on 2/20/17 at 1:05 p.m., the DFS indicated the black substance on the walls around the sink appeared to be "mold". She indicated submitted a "critical" work order to have the sinks caulked with a "mold resistant" caulking, but the work had not been completed to date. 5. One of four garbage cans in the kitchen was observed to be uncovered during the entirety of the kitchen tour. During an interview on 2/20/17 at 1:15 p.m., the DFS indicated it was the facility's policy to have the garbage cans covered. 3.1-21(h)(1) 3.1-21(h)(5)			
F 0412 SS=D Bldg. 00	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside			

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	resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview and record review, the facility failed to provide dental services to a resident with dentures for 1 of 2 residents reviewed for dental services (Resident D). Finding includes: During an interview on 2/21/17 at 3:48 p.m., Resident D indicated she had dentures and they were not lined up. At that time she was observed placing her top and bottom dentures together and her top set of dentures was observed overlapping on top of her bottom set of dentures. She received her dentures about	F 0412	It is the practice of this facility to comply with F412 by providing dental services and assisting residents in making appointments, arranging or transportation. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility has contracted with a dental service as of March 6, 2016. Resident D's family has completed the consent form for the services. Resident D's will be seen at the next scheduled dental visit. Other residents having the potential to be affected by this alleged deficient practice : Current residents requiring dental	03/30/2017

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	a month or two ago and they have not been lined up since she received them. She indicated the Social Services Director (SSD) was supposed to call the dentist to tell him the dentures slipped and they would not line up and the dentist was supposed to make her a new pair. She had to glue her dentures with Fixodent, so they stayed in her mouth. She indicated the problem with her dentures was not being taken care of to meet her satisfaction because she needed new dentures and the SSD needed to find out who was going to be the dentist at the facility because "Two of them are battling it out." Resident D's record review was completed on 2/27/17 at 4:35 p.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, cerebrovascular disease, and dysphagia. The resident had a Care Plan dated 11/28/12, which addressed the problem she had dental or oral cavity health problems as evidenced by needing to be reminded to brush her teeth. Interventions included, but were not limited to, "...12/19/12--Refer patient to dentist/hygienist for evaluation/recommendations re: denture realignment, new fitting, teeth pulled,		services and all new admissions have the potential to be affected. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All residents were assessed for the need of dental services. Nursing will notify social services when a resident requires dental services. Social services will notify the family/responsible and arrange for dental services. Social services will notify the IDT of the residents dental status. The social service director will notify the dental services when a resident requires dental services and will coordinate visits and keep a list to verify the residents who required services are seen. 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: Social services will review frequency of the need for dental services to QA&A. QA&A will review to ensure all residents requiring dental services received dental services in a timely fashion. Deficiencies wil be immediately corrected. QA&A will review monthly and as needed. By what date will the systemic changes be completed: March 30, 2017	

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	repair of carious teeth, 11/28/12--Report changes in oral cavity, chewing ability, S & S [sign and symptom] oral pain, etc." A (Name of Dental Company) report dated 10/13/16, indicated Resident D had her dentures delivered on 10/11/16. The report indicated Recommended Treatment Plan: Schedule Next visit: Delivery Follow Up. During an interview on 2/28/17 at 5:35 p.m., with the Interim Executive Director, the Assistive Living Administrator and the SSD in attendance. The SSD indicated Resident D mentioned to her she had trouble with her dentures being to big, sometime in January 2017, but the SSD did not document the conversation anywhere. She indicated she had the resident's family member sign a new provider consent this day for dental treatment for the new dental provider because the previous dental provider was not coming anymore. The SSD indicated the resident was not having a difficult time chewing her food, so the resident could wait until March 2017, when the new dental provider came to have her dentures fixed. The Assisted Living Administrator indicated at that time, the facility had a problem with their dental provider and the contract the facility had with the provider. She indicated the			

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	previous dental provider would not come back into the facility until the contract issue was settled, so that was why Resident D did not have her dentures fixed. The SSD indicated the new dental provider would be in the facility in March 2017, and the resident would be seen then. The SSD indicated she had not informed the resident's family member regarding the issue with the dental provider in January 2017, when the resident originally complained regarding the dentures to allow her family member an opportunity to take her out of the facility to another dentist to fix her dentures. 3.1-24(a)(3)			
F 0441 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to			

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	§483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview and record review, the facility lacked adequate tracking, trending and follow-up concerning any infectious patterns. This deficient practice had the potential to impact 42 of 42 residents residing in the facility. Finding includes: On 2/28/17 at 8:50 a.m., the infection control tracking, trending and follow-up concerning infectious patterns was reviewed with the Interim Director of Nursing (DON) and the Interim Executive Director (ED). The Infection Control tracking and trending binder had the months with the tracking and trending information dated November 2016, December 2016 and January 2017 in it. During an interview on 2/28/17 at 9:02 a.m., the Interim DON indicated when she arrived at the facility to assume the position as the Interim DON on approximately December 19, 2016, she	F 0441	**The Corrective action accomplished for this alleged deficient practice** DON has been educated on the current infection control practice of the facility **Other residents having the potential to be affected by this alleged deficient practice :** All residents have the potential to be affected. **Measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The facility has an infection control practice that includes tracking and trending of infections. Infections will be logged and tracked/trended weekly, monthly, quarterly, and monthly to identify any infectious patters. **How the corrective action will be monitored to ensure the alleged deficient practice does not recur**	03/30/2017

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	could not find the Infection Control tracking and trending binder, so she started a new one beginning with November 2016. She indicated the months she completed were November 2016, December 2016 and January 2017. She had not completed February 2017 yet. The infections and antibiotics were recorded in the Point Click Care (PCC) program in the computer and she pulled them off the computer for her tracking, trending and follow-up of infectious patterns. She indicated PCC had different categories, which she was able to pull up to view about the infections such as; infection rate report, infection culture report, wound culture report, infection log, infection summary report, etc; She reported the infections tracking and trending every month to the Corporate Nursing Consultant and she reviewed them. She indicated she was able to go back into the computer and look at those previous month's infections and antibiotics used, which were not available when she arrived at the facility. She could not provide tracking, trending and follow-up concerning the infectious patterns because she was unable to produce that information for those months. During an interview on 2/28/17 at 12:30 p.m., the Interim DON provided the		The DON has been in-serviced regarding facility policies/procedures relating to tracking, trending, and follow up concerning any infectious patterns. The DON /or designee will review tracking, trending, and follow up concerning any infectious patterns monthly for three months. **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:** Findings of the audits will be reviewed in monthly QA&A. Deficiencies identified will be immediately corrected. Infection Control will be review in QA&A monthly.	

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	infection control tracking and trending binder once again. She had printed reports off the PCC computer program for the months of April 2016 to October 2016, regarding residents' name, symptoms, types of infections, if they met the criteria of an infection , if a culture was completed with the result, diagnostic tests ordered and results and antibiotics ordered, but there was no tracking, trending or follow-up concerning the infectious patterns for those months provided. A current policy titled "Monthly Surveillance" dated 5/2013, provided by the Interim DON on 2/28/17 at 6:09 p.m., indicated "Information about infections is gathered, monitored and tracked throughout the month. The information is reviewed by the Infection Preventionist for trend identification including trends that may require initiating outbreak investigations. Results are reviewed during the Eagle Room process and QAPI (Quality Assurance Program Improvement) committee meetings. Monthly Infection Surveillance Log: Nursing staff are responsible for entering patient information of the Monthly infection Surveillance Log...The Infection Preventionist manages the process of completing the Monthly Infection Surveillance Log continuously			

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	throughout the month...The infection Preventionist monitors cultures taken including dates and results, the type of precautions and treatment initiated and the date the infection is resolved...The Infection Preventionist trends this information and reports on trends when completing the Monthly Infection Surveillance Log...The Infection Preventionist completes monthly analysis of data, calculation of required infection rates, listing of staff education provided, employee health trends and prepares and reports findings to the center QAPI committee...The Infection Preventionist utilizes the graphing function of the Monthly Infection Surveillance Log to assist with data analysis. The Monthly Surveillance Summary Report is completed at the end of each month...Infection Mapping: The Infection Preventionist identifies cluster activity through the process of infection mapping. Infection mapping utilizes a floor plan diagram of the center where the infections are 'mapped' on the floor plan... Designate a different color for each type of infection...Review the floor plan at the end of the month for groups of colored marks to determine any clustering of organisms. Causative factors are investigated and infection control practice changes to decrease infection rates are recommended as a part			

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	of trend analysis and report to center infection control or QAPI committee...Trend Analysis: Trend analysis is completed after data is collected on the Infection Control Surveillance Log and entered in the Monthly Surveillance Summary Report. The Infection Preventionist identifies trends by...." 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 79 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality Review was completed on March 3, 2017.	R 0000		
R 0117	410 IAC 16.2-5-1.4(b)			

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Bldg. 00	Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on interview and record review, the facility failed to ensure staff met the requirements of First Aid training and certification. This deficient practice had the potential to affect 79 of 79 residents residing in the facility. Finding includes: During the employee record review on 2/28/17 at 2:00 p.m., the staffing records indicated 17 shifts were not staffed with	R 0117	It is the practice of this facility to further comply with R 117 by having applicable personnel certified in First Aid awake and on site at all times. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** C.N.A.s, LPNs, and RNs successfully trained in First Aid	03/30/2017

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	155618	A. BUILDING 00 B. WING	02/28/2017

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	First Aid certified staff. The dates and shifts included were: February 19, 2017--on first shift, second shift and third shift February 20, 2017--on first shift and second shift February 21, 2017--on first shift and second shift February 22, 2017--on first shift, second shift and third shift February 23, 2017--on first shift, second shift and third shift February 24, 2017--on first shift and second shift February 25, 2017--on first shift and second shift During an interview on 2/28/17 at 12:00 p.m., the Human Resources Director indicated she had no further documentation to provide for staffing and first aid certifications. She indicated she was unaware of the first aid requirement for staffing.		**Other residents having the potential to be affected by this alleged deficient practice :** All residents have the potential to be affected. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** C.N.A.s, LPNs, and RNs successfully trained in First Aid Director of Human Resources has added First Aid certification to the new employee checklist, as well as to the annual renewal checklist. **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:** Wellness Director will audit shifts weekly from 4/1/17 – 6/30/17 with results taken to Quality Council; if zero shifts without first aid personnel are found from audit, the audit will cease.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain floors and walls, cover 1 of 4 garbage cans, dry clean pans, and discard 2 dented cans in 1 of 1 kitchen observations. This deficient practice had the potential to affect 79 of the 79 residents being served food from the kitchen. Findings include: The kitchen tour was completed on 02/20/2017 at 12:40 p.m., with the Director of Food Services (DFS) and the Kitchen Manager in attendance. 1. The dry storage area was observed to have the following: One large dented can of Cranberried Jelly	R 0273	It is the practice of this facility to comply with R273 by maintaining a sanitary kitchen environment and the safe storage, preparation, procurement, and service of food. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Dietary staff have been in-serviced on February 20, 2017 dented cans, appropriate drying of dishes. The facility contracted for the re-grouting of the kitchen floor was completed on 03/17/17 The walls have been cleaned, sanitized and repainted by a	03/30/2017

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	One large dented can of Cream of Chicken Soup During an interview with the DFS on 02/20/2017 at 12:50 p.m., she indicated it was the facility's policy to return dented cans to the distributor. 2. The clean pan storage area was observed to have 50 pans with clear liquid on them. The liquid ran down the sides of the stacked pans as they were moved. One stacked pan had clear liquid pooled in the lip edge of pan. During an interview with the DFS on 02/20/2017 at 12:55 p.m., she indicated it was the facility's policy to allow the pans to dry before being placed in the clean storage area. She indicated the dishwashers were aware of the policy. A current policy titled "Cleaning Procedure - Pots and Pans" dated September 2014, was provided by the Director of Food Services on 2/20/17 at 2:17 p.m. "...Remove pans from sanitizing sink. Invert to drain. Air dry. Pans may be stacked once pan is completely dry...." 3. The kitchen floor was observed to have grout eroding. Debris remained trapped between tiles where the grout was eroded,		contractor effective 3/17/17 New garbage pans with self-closing lids have been purchased and in place effective 2/28/2016 **Other residents having the potential to be affected by this alleged deficient practice :** **All residents have the potential to be affected.** The Dietary staff have been in-serviced on February 20, 2017 dented cans, appropriate drying of dishes. The facility contracted for the re-grouting of the kitchen floor was completed on 03/17/17 The walls have been cleaned, sanitized and repainted by a contractor effective 3/17/17 New garbage pans with self-closing lids have been purchased and in place effective 2/28/2016 - During her daily rounds, the Dietary Manager is to discard any dented cans, check the drying of dishes, check on the floor grout, kitchen walls, garbage cans and part of her sanitation rounds. This is to been	

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	after the floor was swept. In the dishwashing area the grout eroded, causing some tiles to be loose. During an interview with the DFS on 02/20/2017 at 1:00 p.m., she indicated it was difficult to maintain the floors with the grout eroded. She indicated she submitted a work order to have the missing grout repaired in the kitchen floors, to date the work had not been done. 4. The walls surrounding the sinks in the dishwashing area were observed to have a black substance in a splatter pattern. The black substance was also observed on the walls under the automatic dishwasher and under the garbage disposal sink. During an interview on 2/20/17 at 1:05 p.m., the DFS indicated the black substance on the walls around the sink appeared to be "mold". She indicated submitted a "critical" work order to have the sinks caulked with a "mold resistant" caulking, but the work had not been completed to date. 5. One of four garbage cans in the kitchen was observed to be uncovered during the entirety of the kitchen tour.		completed during her working days on a daily bases two weeks, 3 x weekly for two weeks, weekly for 2 months. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** During rounds, the Dietary Manager is to discard any dented cans, check the drying of dishes, check on the floor grout, kitchen walls, garbage cans and part of her sanitation rounds. The dietary manager will audit 5 times a week for two weeks, 3 x weekly for two weeks, weekly for 2 months, and no less then monthly thereafter. **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 QA&A team will review monthly for 3 months and continue as needed. **By what date will the systemic changes be completed:** March 30, 2017	

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	During an interview on 2/20/17 at 1:15 p.m., the DFS indicated it was the facility's policy to have the garbage cans covered.			