STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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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 IN00284455. Complaint IN00284455- Substantiated. Federal/State deficiency related to the allegations are cited at F-689 and F-690. Survey dates: January 22, 23, 24, 25, 28, 29, 30, & 31 2019. Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 94 SNF: 3 Residential: 31 Total: 128 Census Payor Type: Medicare: 23 Medicaid: 51 Other: 23 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 8, 2019	F 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately reflect a resident's status on a MDS (Minimum Data Set) Assessment in 1 of 23 residents reviewed. (Resident 79) Findings include: The clinical record for Resident 79 was reviewed on 1/29/19 at 1:45 p.m. The diagnoses included, but were not limited to, pressure ulcer of sacral region and muscle weakness. Resident 79 was admitted on 12/28/18. An admission MDS, dated 1/4/19, noted a stage 2 pressure ulcer. A document titled "Event Report", dated 1/7/19, indicated the following, "...Description...Stage II [two] pressure area to coccyx...." A document titled "IDT [interdisciplinary team] Clinically At Risk Review", dated 1/10/19, indicated the following, "...Description...Stage II pressure area to coccyx...Current status:...Stage II to coccyx...." Upon review of the admission nursing assessment and the progress notes, there was no indication Resident 79 had a pressure area upon admission. A progress note, dated 1/7/19 at 9:19 p.m., indicated Resident 79 had an open area to her coccyx. A progress note, dated 1/13/19, at 2:01 a.m., indicated Resident 79 had a pressure area to her coccyx.	F 0641	**F641 Accuracy of Assessments CFR(s): 483.20(g)** **I. The MDS for resident #79 was modified in accordance with the Resident Assessment Instrument Comprehensive User Manual and re-submitted.** **II. All residents with open areas have the potential to be affected by the alleged deficient practice. All residents with open areas have been reviewed to determine their MDS is accurate.** **III. Education will be provided to MDS personnel and nursing administration regarding correct coding of the MDS for pressure ulcers. The systemic change includes the MDS coordinator /designee will review the facility wound summary report to determine how to code a wound for a resident on the MDS during the reference period. Based on the RAI manual guidelines, the MDS coordinator/designee will complete the assessment.** **IV. The MDS coordinator/designee will audit for accuracy of coding for open**	03/01/2019

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	A progress note, dated 1/13/19 at 9:24 p.m., indicated Resident 79 had a stage 2 pressure ulcer to her coccyx. A progress note, dated 1/17/19 at 2:09 p.m., indicated a stage 2 pressure ulcer to Resident 79's coccyx remained. A progress note, dated 1/18/19 at 8:50 p.m., indicated the open area to Resident 79's coccyx was resolved. There was no documentation that included further assessment of the pressure ulcer to Resident 79's coccyx. An interview conducted with Clinical Support 8, on 1/28/19 at 11:05 a.m., indicated there was never a pressure ulcer to Resident 79's coccyx. Resident 79's Admission MDS Assessment was incorrect. She further indicated there is no policy for inaccurate MDS Assessments. The facility follows the Resident Assessment Instrument (RAI) guidelines. Current RAI Manual guidelines from October, 2018, for completing skin conditions indicated the following, "...Steps for Assessment...1. Review the medical record, including skin care flow sheets or other skin tracking forms...2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review...3. Examine the resident and determine whether any skin ulcers/injuries are present...."		**areas prior to submission of the MDS. This audit will be ongoing at 100% x 2 months, then 10 assessments per week x 1 month, then 5 assessments per week x 1 month, then 3 assessments per week x 2 month. The MDS consultant/designee will randomly audit 5 residents for MDS accuracy related to coding of open areas weekly for 8 weeks then monthly for 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.** **COMPLIANCE DATE: March 1, 2019**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and			

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	implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of			

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	this section. Based on observation, interview and record review, the facility failed to ensure a care plan for a resident identified as a fall risk with an intervention for extensive assistance of 2 persons with transfers was implemented for 1 of 5 residents reviewed for falls. (Resident H) The clinical record for Resident H was reviewed on 1/30/19 at 11:18 a.m. Her diagnoses included, but were not limited to rheumatoid arthritis, diabetes with polyneuropathy, muscle weakness, right ankle contracture, anemia, chronic ischemic heart disease, atrial fibrillation and osteoporosis. Her most recent Minimum Data Set assessment, dated 12-26-18, indicated she was cognitively intact, requires extensive assistance of two or more persons for transfers from one surface to another, such as from wheelchair to bed. It indicated she is non-ambulatory and uses a wheelchair for mobility. During a care observation for transfers on 1/30/19 at 1:01 p.m., with CNA 3, she indicated Resident H "is actually a one person transfer, but her paperwork [resident information provided to facility staff indicating how a resident is to receive care and services] hasn't been updated from the two person assist." CNA 3 was observed to speak with Resident H regarding transferring her from the wheelchair and into the bed. CNA 3 was observed to secure a gait belt to the resident's waist area prior to her cueing the resident as to each step of the transfer with no additional assistance of other persons. In continued interview with CNA 3 at this time, she indicated she returned to work at this facility more than 3 months ago and the aide assignment paperwork indicated this resident required	F 0656	**F656 Development/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)** **I. Resident #H has a care plan in place that addresses her transfer assist needs. CNA 3 has received education on following the plan of care and CNA assignment sheet for transfer needs.** **II. All residents requiring transfer assistance have the potential to be affected. These residents have all been reviewed for transfer needs, their care plans reviewed and their C.N.A. assignment sheets have been updated.** **III. Education will be provided to all nursing staff related to following the plan of care and C.N.A. assignment sheets for transfer needs. The systemic change includes all residents will be reviewed by the Interdisciplinary Team upon admission, quarterly and with significant change to determine they have an accurate care plan in place to address their transfer needs. Their C.N.A. sheets will be**	03/01/2019

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	extensive assistance of 2 persons for transfer, "But we have been transferring her with just one person since then, as far as I know." A care plan for fall risk related to Resident H's history of poor balance and weakness, with an initiation date of 2-16-15 and most recently revised on 12-27-18, indicated an intervention added on 3-23-17, specified for the assistance of 2 persons for transfers. In an interview on 1/30/19 at 02:01 p.m., with the Director of Nursing, she specified the facility's policy regarding transfers is that staff are to follow the care plan or the aide assignment sheet for how to transfer and with the number stated in the care plan or aide assignment sheet. On 1-30-19 at 4:10 p.m., the Clinical Support Nurse provided a copy of a policy entitled, "Using the Care Plan." This undated policy was identified as the current policy utilized by the facility. This policy indicated, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...The Nurse Supervisor uses the care plan to complete the CNA's daily/weekly work assignment sheets and/or flow sheets. CNA's are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved....Documentation must be consistent with the resident's care plan..." 3.1-35(b)(1)		**reviewed for accuracy.** **IV. The DON/Designee will review through direct observation of transfers to determine the plan of care and C.N.A. assignment sheet is being followed. This will occur 7 days per week on all shifts with 5 residents 5 times weekly for 1 month and then 5 times monthly thereafterto total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: March 1, 2019**	
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

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Bldg. 00	§483.24(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 provide nail care, shaving needs and showers for a dependent resident for 1 of 1 resident reviewed for Activities Of Daily Living (Resident C). Finding include: During an observation and interview on 1/24/19 at 9:59 a.m., Resident C was laying in bed, his nails were long with black debris underneath them on both hands. The resident agreed his nails needed cleaned and trimmed. The resident had a moderate amount of facial and neck hair. The resident indicated he did not like to have a facial and neck hair and liked to be clean shaven. The resident indicated he was not getting any showers and would like to have one to two showers a week. During an observation on 1/25/19 at 2:27 p.m., Resident C was laying in bed and had an moderate amount of facial and neck hair and his fingernails on both hands were long with black debris underneath them. During an observation on 1/28/19 at 11:21 a.m., Resident C had a moderate amount of facial and neck hair and his fingernails on both hands were long with black debris underneath them. The resident indicated he still had not had a shower and could not recall the last time he had a shower or had his fingernails cleaned or trimmed. Review of the record of Resident C on 1/28/19 at 2:20 p.m., indicated the resident's diagnoses	F 0677	**F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)** **I. Residents C has received showers/ baths per his individual preference.** **Residents C has received nail care.** **Resident C has been shaved per his preference.** **II. All residents that need assistance for ADL care have the potential to be affected by the alleged deficient practice.** **All residents requiring assistance for ADL care have been reviewed.** **They are receiving showers, nail care and shaving per their preference.** **III. Education has been provided to all staff regarding providing ADL care including grooming of facial hair and nail care. The systemic change includes Charge Nurses will be responsible to ensure care needs** **are met to include nail care, shaving, and**	03/01/2019

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	included, but were not limited to, dementia without behaviors, urinary tract infection, acute kidney failure, pain, hypertension, osteoarthritis, muscle weakness and depression. The plan of care for Resident C, dated 12/17/18, indicated the resident was unable to independently perform late loss activities of daily living related to decline in mobility. The resident requires 1-2 staff (mostly 2 staff). The Significant Change Minimum Data Set (MDS) for Resident C, dated 12/14/18, indicated the resident had severe impairment for daily decision making. The resident had the ability to usually understand and usually had the ability to make himself understood. The resident did not have any rejection of care. It was very important for the resident to choose between a bed bath and shower. The resident required extensive assistance of one person for personal hygiene and was totally dependent of one person for bathing/showers. The preference sheet for Resident C dated, 6/22/18, indicated the resident preferred a shower for bathing needs twice a week in the morning. Review of Resident C's showers 10/1/18 to 12/28/19 indicated the resident received 3 showers and 1 complete bed bath in October 2018, the resident received 2 showers and 7 complete bed baths in November 2018, the resident received no showers in December 2018 or January 2019, the resident did receive 16 complete bed baths during this time. During an interview with CNA 6 on 1/28/19 at 2:58 p.m., indicated the aides were responsible to clean and trim Resident C's fingernails because he was		**showering/bathing. Each resident will have an associate assigned to them. The assigned representatives will assist in monitoring the resident to ensure compliance with ADL care.** **IV.** **The DON/designee will audit through direct observation 5 random residents for ADL care to include showers are received and shaving and nail care are provided. This auditing will occur daily (including Saturday and Sunday) for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.** **COMPLIANCE DATE: March 1, 2019**	

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	not a diabetic. Review of the CNA assignment sheet provided by CNA 6 on 12/28/19 at 3:00 p.m., indicated Resident C was scheduled to have showers twice a week on evening shift. During an interview with RN 2 on 1/28/19 at 3:30 p.m., indicated Resident C could not take a shower because he had a wound vac in place. RN 2 indicated she was unsure if there was physician order to not give the resident a shower. During an interview with RN 2 on 1/29/19 at 10:32 a.m., indicated she called the wound center on 1/28/19 and they did not want running water on Resident C's wound. RN 2 indicated there was no prior documentation of these instructions until yesterday. RN 2 indicated Resident C started on the wound vac on 12/4/18. RN 2 indicated the staff did cut and clean his fingernails yesterday. During an observation and interview on 1/29/19 at 12:09 p.m., Resident C was laying in bed, he had a moderate amount of facial and neck hair. The resident indicated the staff had cut and cleaned his fingernails, but he still had not been shaved. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to assess, monitor and treat a resident with black discolored fingernails for 1 of 1 resident reviewed for skin condition (Resident 70). Finding include: During an observation on 1/23/19 at 11:46 a.m., the resident's ring finger and pointer finger on left hand was black and purple. Review of the record of Resident 70 on 1/25/19 at 2:36 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, muscle weakness, expressive language disorder, atrial fibrillation, vascular dementia without behaviors, excoriation skin picking disorder and diabetes. The Admission Minimum Data Set (MDS) assessment for Resident 70, dated 1/10/19, indicated the resident was admitted to the facility on 1/3/19. The resident was severely impaired for daily decision making. The resident required extensive assistance of one person for transfers, bed mobility, dressing, toilet use and personal hygiene. The physician order for Resident 70, dated 1/3/19, indicated the resident was ordered a weekly head to toe skin assessment by a licensed nurse and if there were any new areas noted complete a change of condition event. The skin assessment for Resident 70, dated 1/25/19, indicated no skin issues.	F 0684	**F684 Quality of Care CFR(s): 483.25** **I. Resident # 70 has a current skin assessment identifying the discoloration to his first and third digits on his left hand.** **II. All residents at risk for nail bed discoloration have the potential to be affected. An in house skin sweep will be conducted by the DON/Designee by 2/22/19 to identify any areas of skin concern including nail discoloration. The current skin assessments will be reviewed for accuracy. Any issues identified will be corrected.** **III. Education will be provided to all nursing staff related to identification of skin concerns and completing documentation when areas are identified. The systemic change includes that nurses and CNAs will be educated upon hire and annually that any skin concerns are reported upon identification to the nurse. Education will also include documentation of weekly skin assessments.** **IV. The Director of nursing or designee will complete a**	03/01/2019

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	During an observation on 1/25/19 at 3:15 p.m., both fingers nail bed on the left hand remain black and purple. The resident indicated he smashed his fingers. During an interview and observation on 1/28/19 at 2:53 p.m., Resident 70's pointer finger and ring finger on the left hand remained black, the resident indicated he pinched them. LPN 1 indicated Resident 70's fingernails had looked like that since his admission and she was unsure what had caused the discoloration of his fingernails. LPN 1 indicated she was not able to find any documentation of his two fingernails being black. During an interview with RN 2 on 1/29/19 at 10:37 a.m., Resident 70 reported his fingers did not hurt. RN 2 had requested the physician to assess the resident's fingers today. There was no documentation of the resident's fingers discoloration prior to 1/28/19. RN 2 indicated she called the resident's family and they did not know what happened his fingers and he was unable to tell me what happened to his fingers. During an interview with RN 2 on 1/29/19 at 12:11 p.m., indicated the physician had assessed Resident 70's fingers and wanted the resident's fingernails soaked in soap and water as he thought it might be fungus but was unsure at this time. The skin assessment policy provided by Clinical Support 8 on 1/29/19 at 1:51 p.m., indicated residents would have a head to toe assessment completed by a licensed nurse on admission and every week thereafter. "The nurse doing the assessment will document any abnormal findings affecting the skin.		**random audit of resident's skin assessments for accuracy. This auditing will occur daily for 5 residents for 4 weeks; then, monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: March 1, 2019**	

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	3.1-37			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview and record review, the facility failed to address a resident's missing hearing aids for 1 of 1 residents reviewed for hearing. (Resident 83) Findings include: The clinical record for Resident 83 was reviewed on 1/29/19 at 9:30 a.m. The diagnoses included, but were not limited to, transient cerebral ischemic attack and spondylolysis. An interview conducted with Family Member 10, on 1/24/19 at 10:36 a.m., indicated Resident 83 had hearing aids in the past but believed they were lost and have been for a year. Resident 83 was observed, at the time of interview, without hearing aids present. An interview conducted with (CNA) Certified Nursing Assistant 9, on 1/29/19 at 9:46 a.m.,	F 0685	**F685 Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)** **I. The family of Resident #83 have signed the agreement for senior well who will see her on their next visit.** **II. All residents with hearing aides have the potential to be affected by the alleged deficient practice. All residents with hearing aides have been reviewed to determine they have hearing aides available for their use.** **III. Education will be provided to all nursing staff on reporting missing hearing aides to the Social Services Director. The**	03/01/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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	indicated Resident 83 did not have hearing aids noted on the CNA assignment sheet and was unsure if she had ever had hearing aids. An interview conducted with Registered Nurse 11, on 1/29/19 at 9:50 a.m., indicated Resident 83 had hearing aids in the past but does not have them at this time. A care plan for communication, revised 1/15/19, indicated the following, "...Resident has hearing loss and uses hearing aide(s) [sic]...Check that hearing aid(s) is clean, functioning, and properly placed into ear(s). Store hearing aid(s) at bedside...." An interview conducted with Social Service Designee 12, on 1/30/19 at 9:48 a.m., indicated she spoke with Resident 83's power of attorney and they indicated the hearing aids have been missing for a while. She was not aware of Resident 83 not having a hearing aid until surveyor brought it to her attention. An interview conducted with Clinical Support 8, on 1/31/19 at 10:20 a.m., indicated there must have been a lack of communication with the nurses and the social workers. Social services would have followed-up with the matter if there was communication of such. The care plan would then have been updated with any additional information based on what the resident and/or family wishes were. A policy titled "Using the Care Plan", revised August 2006, was provided by Clinical Support 8, on 1/30/19 at 10:50 a.m. The policy indicated the following, "...The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have		**systemic change will include implementation of a missing property form for notification is hearing aides are missing.** **IV. The Social Services Director will complete a random audit of resident who have hearing aides to determine they are available. This auditing will occur daily for 5 residents for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLETION DATE: March 1, 2019**	

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	responsibility for providing care or services to the resident...." 3.1-39(a)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to follow and update a resident's plan of care for two person assistance with transfers and utilize a gait belt during a transfer that resulted in resident being lowered to the floor and later identified with a right humerus fracture, failed to utilize a gait belt during a transfer and failed to to transfer a resident with two staff as careplanned for 3 of 6 residents reviewed for accidents (Resident D, Resident G and Resident H). Findings include: 1. The clinical record for Resident D was reviewed on 1/25/19 at 12:50 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, repeated falls and muscle weakness. The MDS (Minimum Data Set) Assessments, dated 6/24/18 through 12/3/18, noted Resident D to need extensive assistance of two staff person	F 0689	**F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)** **I. Residents D,G and H are currently being transferred per their Plan of care and C.N.A. assignment sheet.** **II. All residents requiring transfer assistance have the potential to be affected. These residents have all been reviewed for transfer needs, their care plans reviewed and their C.N.A. assignment sheets have been updated. CNAs 3 and 4 have been educated on gait belt use, following the Plan of care and C.N.A. assignment sheet related to transfers.**	03/01/2019

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	for transfers. A document from the Indiana State Department of Health Survey Report System, dated 11/20/18, indicated the following, "...[name of Resident D]...Resident was lowered to the floor on 11/19/18 at 11:38 p.m. by staff member...On 11/20/18 at 12:42 pm resident complaints of right shoulder and arm pain. MD [medical director] notified and ordered right arm x-ray...X-ray results show right humerus fracture...." A progress note, dated 11/19/18 at 11:38 p.m., indicated the following, "...Resident was being assisted from wheelchair to bed. When resident's legs gave out on him. Resident was lowered to the ground without hitting his head...." A "Witness Statement Form", dated 11/21/18, was completed by (CNA) Certified Nursing Assistant 22. The document indicated the following, "...I was transferring [name of Resident D] to the bed from the wheelchair and he leaned to the right. I had to try to ease him to the floor. He was leaned up against his recliner...." An "Employee Notice Form", dated 11/21/18, indicated the following, "...[x] in box...Written Warning...Summary of the Infraction:...Resident a 2 person assist and staff member transferred per self. No gait belt used...." An interview conducted with Clinical Support 8, on 1/29/19 at 11:11 a.m., indicated Resident D was a two person assist prior to the incident, on 11/19/18, involving Resident D being lowered to the floor by CNA 22. Staff should utilize a gait belt with transfers as per recommendations. A care plan for activities of daily living (ADL's),		**III. Education will be provided to all nursing staff related to Gait belt use, following the plan of care and C.N.A. assignment sheets for transfer needs. The systemic change includes education upon hire and annually related to the use of gait belts, following the C.N.A. assignment sheets and following the plan of care for transfer needs.** **IV. The DON/Designee will review through direct observation of transfers to determine gait belt use, plan of care and C.N.A. assignment sheet are being followed. This auditing will occur daily (including Saturdays and Sundays) on all shifts for 5 residents for 4 weeks; then, monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: March 1, 2019**	

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	revised 11/30/18, indicated the following, "...Resident is unable to independently perform late loss ADL's R/T [related to] debility and requires extensive assist of 1-2 for bed mobility, transfers, toileting...Approach...09/15/2017...Hoyer lift for transfers...Use gait belt x1 [times one] assist for transferring...." A document identified as the CNA assignment sheet, undated, indicated Resident D is extensive assist with two staff person for transfers and requires the use of a mechanical lift. An interview conducted with RN 2, on 1/29/19 at 10:52 a.m., indicated Resident D has always been a two person assist with transfers. After this incident there was an audit completed of residents' transfer status and updated the CNA assignment sheet if needed. There was disciplinary action noted towards CNA 22 after this incident involving Resident D. An interview conducted with Clinical Support 8, on 1/25/19 at 1:26 p.m., indicated CNA 22 transferred Resident D by herself and he was lowered to the floor after his legs started to "buckle". CNA 22 did not utilize a gait belt during this transfer of Resident D. An interview conducted with the Director of Nursing, on 1/25/19 at 1:36 p.m., indicated CNA 22 was under the impression that Resident D was a one person assist with transfers and she responded "no, he is a two person". Resident D has always been a two person assist with transfers since she has been at the facility. He was a two person assist but did not utilize a mechanical lift prior to this incident. 2. During an observation on 1/28/19 at 11:38 a.m., CNA 4 provided incontinent care for Resident G and			

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	assisted the resident to get dressed. The aide reached under the residents arms with her arms and attempted to transfer the resident to her wheelchair the resident was very stiff and could not bend her legs or waist. CNA 4 lifted the resident off the bed under the resident's arms but was not able to complete the transfer. When queried if she had been issued a gait belt or if the facility used gait belts for transfers she indicated they were available but she had not gotten a gait belt yet. The CNA pushed the call light for assistance, she indicated her CNA assignment sheet said the resident was a one person transfer, but she was not able to transfer Resident G alone. RN 5 came into Resident G's bedroom on 1/28/19 at 11:59 a.m., and assisted with the transfer using a gait belt that was in the resident's bathroom. RN 5 indicated all residents had a gait belt located in their bathroom. CNA 4 indicated she was not aware that gait belts were located in the residents bathrooms. The transfer required both staff with no assistance from the resident. RN 5 indicated Resident G had days that she was stiff and required two staff for transfers. During an interview with RN 2 on 1/29/19 at 10:38 a.m., indicated therapy was going to screen Resident G for transfers. Review of the record of Resident G on 1/29/19 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, muscle weakness, insomnia, osteoarthritis, vascular dementia, with behavioral disturbance, chronic pain, hypertension, major depressive disorder and anxiety. The Quarterly Minimum Data Set (MDS) assessment for Resident G, dated 12/19/18,			

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	indicated the resident was extensive assistance of one person for transfers. The plan of care for Resident G, dated 12/24/18, indicated the resident required extensive assistance of 1-2 staff, her ability varies from day to day for transfers. The intervention included, but were not limited to, transfer resident with a gait belt and assist of one staff. The plan of care for Resident G, dated 1/21/19, indicated the resident was at risk for falling and falling related injuries related to dementia, poor safety awareness, poor balance, potential medication side effects and unsteadiness on her feet. 3. The clinical record for Resident H was reviewed on 1/30/19 at 11:18 a.m. Her diagnoses included, but were not limited to rheumatoid arthritis, diabetes with polyneuropathy, muscle weakness, right ankle contracture, anemia, chronic ischemic heart disease, atrial fibrillation and osteoporosis. Her most recent Minimum Data Set assessment, dated 12-26-18, indicated she was cognitively intact, requires extensive assistance of two or more persons for transfers from one surface to another, such as from wheelchair to bed. It indicated she is non-ambulatory and uses a wheelchair for mobility. During a care observation for transfers on 1/30/19 at 1:01 p.m., CNA 3 indicated Resident H "is actually a one person transfer, but her paperwork [resident information provided to facility staff indicating how a resident is to receive care and services] hasn't been updated from the two person assist." CNA 3 was observed to speak with Resident H regarding transferring her from the wheelchair and into the bed. CNA 3 was observed to secure a gait belt to the resident's waist area prior to her cueing the resident as to			

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	each step of the transfer with no additional assistance of other persons. In continued interview with CNA 3 at this time, she indicated she returned to work at this facility more than 3 months ago and the aide assignment paperwork indicated this resident required extensive assistance of 2 persons for transfer, "But we have been transferring her with just one person since then, as far as I know." A care plan for fall risk related to Resident H's history of poor balance and weakness, with an initiation date of 2-16-15 and most recently revised on 12-27-18, indicated an intervention added on 3-23-17, specified for the assistance of 2 persons for transfers. In an interview on 1/30/19 at 02:01 p.m., with the Director of Nursing, she specified the facility's policy regarding transfers is that staff are to follow the care plan or the aide assignment sheet for how to transfer and with the number stated in the care plan or aide assignment sheet. On 1-30-19 at 4:10 p.m., the Clinical Support Nurse provided a copy of a policy entitled, "Using the Care Plan." This undated policy was identified as the current policy utilized by the facility. This policy indicated, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...The Nurse Supervisor uses the care plan to complete the CNA's daily/weekly work assignment sheets and/or flow sheets. CNA's are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been			

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	achieved....Documentation must be consistent with the resident's care plan..." A policy titled "Fall Prevention Policy and Procedure", dated May 2016, was provided by Clinical Support 8 on 1/25/19 at 1:25 p.m. The policy indicated the following, "...Care Planning...Fall risk care plans will be kept current by the IDT and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system...." A document titled "Transfer to Wheelchair", undated, was provided by Clinical Support 8 on 1/29/19 at 1:51 p.m. The document indicated the following, "...1. Do initial steps...4. Stand in front of resident and apply gait belt in front of resident's abdomen...15. Do final steps...." A policy titled "Activities of Daily Living (ADL), Supporting", revised March 2018, was provided by Clinical Support 8 on 1/29/19 at 1:51 p.m. The policy indicated the following, "...Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry of activities of daily living...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:...b. Mobility (transfer and ambulation)...." This Federal tag relates to Complaint IN00284455. 3.1-45(a)(1) 3.1-45(a)(2)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure physician orders for urine testing and urine testing samples were obtained in a	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** **CFR(s): 483.25(e)(1)-(3)**	03/01/2019

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	timely manner for 1 of 3 residents reviewed for UTI's (urinary tract infections) and urinary catheters. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1-28-19 at 12:00 p.m. Her diagnoses included, but were not limited to, UTI and urinary retention with a urinary catheter in place during her stay at the facility. Her admission Minimum Data assessment, dated 10-17-18, indicated she was moderately cognitively intact, required extensive assistance of two or more persons with bed mobility, transfers and toileting, and had a urinary catheter in place. In a telephone interview with a family member of Resident B on 1/30/19 at 9:48 a.m., she recalled Resident B had self-catherized herself for several years prior to admission to the facility and "had a standing order for Cipro [an antibiotic] in case we noticed any signs of an infection." She described signs and symptoms of Resident B's UTI's as "confusion, she doesn't know nobody and just out of her head." The family member described Resident B as becoming, within a week of admission, "confused and just out of her head," and this was brought to the attention of the facility. "But they kept saying it was her pain pills that was causing her to be confused. I kept telling them she had been on the same pain pills for years." She indicated she had requested the facility obtain an urinalysis (UA, test for UTI) "on a Wednesday or Thursday, but it was Monday before they actually got the urinalysis. By then, she was resistant to the Cipro I had brought in and had told them I was giving to her, from her standing order." The family member indicated she had requested the facility obtain a UA for several		**I. Resident B no longer resides in the facility.** **II. All residents with a physician order to obtain urine testing have the potential to be affected by the alleged deficient practice. An audit for active residents within the past 30 days has been completed to determine urine testing was done per order.** **III. Education will be provided to all licensed nursing staff related to following physician orders for urine testing. The systemic change will include using the local hospital laboratory for urinalysis testing on weekends/holidays if needed.** **IV. The DON/Designee will audit all lab orders related to urine testing to determine they are completed timely. This auditing will occur daily for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Compliance Date: March 1,**	

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	days in a row, she had requested the facility obtain a UA, but each time was told the facility staff "had forgotten," to obtain the UA and was told "several times that they didn't have an order. Well that doesn't make sense, because, one they have a phone to call the doctor to get the order and two, they kept saying they had forgotten to get the UA, as in, it sounded like to me, they already had the order." Review of the physician orders indicated orders were obtained on 10-19-18, 10-21-18 and 10-22-18, for a UA and culture and sensitivity, as well as additional orders on 10-21-18 and 10-22-18, to remove and replace urinary catheter and obtain a UA and culture and sensitivity (C&S). Review of Resident B's nursing progress notes reflected facility staff had documented signs and symptoms of confusion on 10-19-18 at 12:50 a.m. and 7:27 a.m. On 10-20-18 at 6:50 a.m., an entry indicated the family expressed concern the facility had not yet obtained a urine specimen for a UA and subsequently had begun treatment for a possible UTI with Cipro 500 milligrams (mg) which the family had been administering. An entry, dated 10/22/2018 at 1:18 a.m., "UA C&S collected. New foley placed... Remains confused et [and] attempted to get up out of bed to go to the market. Reoriented to current time of day." In an interview on 01/31/19 at 10:37 a.m. with the Director of Nursing (DON), she indicated when she reviewed the electronic medical record, "I could not find where the UA order for 10-19-18 populated into the system. Plus, with that being on a Friday, the lab would have picked it up at 5am that morning and would not be back until Monday [10-22-18] at 5am because it was not put in as a stat order. We do have the ability to take		**2019**	

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	our labs over to the hospital, if needed. I can't really tell you why the UA was not gotten sooner. The nursing note from 10-22-18 says the UA was obtained, then says the foley was changed. Unfortunately, since that nurse no longer works here, I cannot ask her what the sequence was, but from the way the note is written, it sounds like she got the urine specimen before the catheter was changed. A care plan developed on 10-14-18 for Resident B, regarding her indwelling urinary catheter had the following interventions listed: - report any signs or symptoms of UTI to the MD, NP or PA. -labs as ordered by the MD. On 1-30-19 at 9:05 a.m., the DON provided a copy of an undated policy entitled "Urinary Tract Infections/Bacteriuria." This policy was identified as the current policy utilized by the facility. This policy indicated, "As a part of the initial assessment, the physician will help identify individuals who have a history of symptomatic urinary infections, and those who have risk factors (for example, an indwelling catheter, urinary outflow obstructions, etc., for UTI's. The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI. Nurses should observe, document, and report signs and symptoms (for example, fever or hematuria) in detail...There is no consistent, clear presentation of symptomatic UTI's. New onset of nonspecific symptoms alone (change in mental status, decline in appetite, etc.) is not a reliable indicator of a UTI, unless there are other general or localized symptoms...The physician will order appropriate treatment for verified or suspected UTI's based on a pertinent assessment."			

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	155481	A. BUILDING 00 B. WING	01/31/2019

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	This Federal tag relates to Complaint IN00284455. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to administer medications per recommendations on an empty stomach and/or before a meal that resulted in a 5.26% medication error rate for 2 of 5 residents reviewed for medication administration. (Resident 4 and 31) Findings include: 1. An observation was conducted of (RN) Registered Nurse 5 preparing medications for Resident 4 on 1/30/19 at 8:30 a.m. Medications were prepared and placed in a medication cup to where Resident 4 took all prepared medications by mouth. A breakfast tray was noted on Resident 4's bedside table with no more food present. Resident 4 indicated, at that time, she was finished eating breakfast. The medications administered to Resident 4 included Synthroid and omeprazole. The clinical record for Resident 4 was reviewed on 1/30/19 at 10:00 a.m. The diagnoses included, but were not limited to, hypothyroidism and gastro-esophageal reflux disease. A physician order, dated 3/15/17, noted the following, "...omeprazole capsule, delayed release	F 0759	**F759 Free of Medication Error Rts 5% or More** **CFR(s): 483.45(f)(1)** **I. Residents 4 and 31 are receiving their medications per manufacture's recommendation and current physician orders.** **II. All resident with orders for Omeprazole and Synthroid have the potential to be affected by the alleged deficient practice. All residents with these medications have been reviewed by the Licensed Pharmacist with recommendations made for time adjustments. Orders for changing medication times have been obtained from the Physician and have been**	03/01/2019

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	10 mg [milligrams]...Upon Rising 07:00 AM - 11:00 AM...." Another physician order, dated 5/3/17, noted the following, "...Synthroid tablet; 75 mcg [micrograms]...Upon Rising 07:00 AM - 11:00 AM...." 2. An observation was conducted of RN 5 preparing medications for Resident 31 on 1/30/19 at 9:05 a.m. Medications were placed in a medication cup to where Resident 31 took all prepared medications by mouth. The medications included omeprazole. Resident 31 indicated, at the time of observation, that she had finished consuming breakfast prior to medication administration. The clinical record for Resident 31 was reviewed on 1/30/19 at 10:02 a.m. The diagnosis included, but were not limited to, gastro-esophageal reflux disease. A physician order, dated 4/12/18, noted the following, "...omeprazole capsule, delayed release; 20 mg [milligrams]...Once A Day Upon Rising 07:00 AM - 11:00 AM...." The drug label for omeprazole indicated the medication should be taken before eating. The drug label for Synthroid indicated the administration, preferably, of one-half to one-hour before breakfast. An interview conducted with Clinical Support 8, on 1/31/19 at 10:20 a.m., indicated Synthroid and omeprazole are noted to be given on an empty stomach. The facility is in contact with the physician to see about changing medication		**implemented.** **III. Education will be provided to all licensed nurses related to administration times of Synthroid and Omperazole. The systemic change will include reviewing all new orders for Synthroid and Omperazole to determine they are ordered to be administered on an empty stomach.** **IV. The DON/Designee will audit new orders daily during the clinical stand up meeting to determine if medication times for Omeprazole and Synthroid are ordered correctly. This auditing will occur daily for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Compliance Date: March 1, 2019**	

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	administration times. 3.1-48(c)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(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			

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	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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure infection control was maintained during medication	F 0880	**F880 Infection Prevention &**	03/01/2019

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	administration and failed to wash hands before and after resident care for 3 of 5 residents reviewed for infection control. (Resident 4, Resident 31, Resident 75 and Resident H). Findings include: 1 a. An observation was conducted of medication preparation for Resident 4 on 1/30/19 at 8:30 a.m. Medications were prepared by (RN) Registered Nurse 5 that included pills to be administered by mouth and two subcutaneous injections of insulin. Pills were taken with water and insulin was injected into Resident 4's abdomen by RN 5 while she was wearing gloves. RN 5 proceeded to remove the gloves and continue to prepare medications for another resident without performing hand hygiene. 1 b. An observation was conducted of medication preparation for Resident 75 on 1/30/19 at 8:45 a.m. Medications were prepared that included pills to be administered by mouth and two subcutaneous injections of insulin. While preparing medications for Resident 75, a red capsule had accidentally fallen onto the floor. The red capsule was identified as isosorbide mononitrate extended release capsule 30 milligrams. RN 5 proceeded to discard the red capsule and continue to prepare medications for Resident 75 without performing hand hygiene. RN 5 proceeded to don clean gloves, administer pills and inject insulin into Resident 75's abdomen. RN 5 then removed her gloves and continued to prepare medications for another resident without performing hand hygiene. 1 c. An observation was conducted of medication administration for Resident 31 on 1/30/19 at 9:05 a.m. Medications were prepared and included pills		**Control** **CFR(s): 483.80(a)(1)(2)(4)(e)(f)** **I. Residents 4, 31, 75 and Resident H have not had any signs or symptoms of new infections since the ending of the annual survey. RN # 5 and C.N.A. #3 have been educated on proper hand hygiene.** **II. All residents receiving medications and care from staff have the potential to be affected by the alleged deficient practice.** **III. Education will be provided to all nursing staff related to hand hygiene. The systemic change includes education upon hire and annually related to hand hygiene.** **IV. The DON/Designee will audit through direct observation hand hygiene during resident care and medication pass. This auditing will occur daily (including Saturdays and Sundays) on all shifts for 5 residents for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be**	

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	and eye drops. RN 5 applied gloves and administered pills and eye drops to Resident 31. An interview conducted with RN 5, on 1/30/19 at 9:20 a.m., indicated she should perform hand hygiene before and after contact with a resident and/or when she contaminated her hands by picking up a pill off of the ground. An interview conducted with the Director of Nursing (DON), on 1/30/19 at 9:50 a.m., indicated staff should perform hand hygiene before and after administration of medications between residents. 2.) Prior to a care observation for Resident H for transfers on 1/30/19 at 1:01 p.m., CNA 3 was observed to enter the building from outdoors, remove her coat, enter Resident H's room, not wash her hands and don gloves, prior to initiation of care. Upon completion of care and services, CNA 3 was observed to remove her gloves and exit from the room without washing her hands. CNA 3 was interviewed immediately upon exiting the room. CNA 3 indicated she normally washes her hands prior to and post care, but was in a hurry today. In an interview on 1/30/19 at 2:01 p.m., with the Director of Nursing (DON), she stipulated the facility's policy is that handwashing is to be done before and after resident care and as needed during resident care. A document titled "Licensed Nurse Med [medication] Pass Clinical Skills Validation", undated, was provided by the DON on 1/30/19 at 10:00 a.m. The document indicated the following, "...4. Wash hands before medication pass...6. Check medication administration record...7. Gel hands...8. Remove medication from drawer...19. Cart was locked...20. Gel hands...."		**adjusted as needed.** **COMPLIANCE DATE: March 1, 2019**	

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	On 1-31-19 at 9:05 a.m., the DON provided a copy of a policy and procedure entitled, "Handwashing/Hand Hygiene Policy." This undated policy was indicated to be the current policy utilized by the facility. This policy indicated, "...Employees must wash their hands for at least twenty (40-60) [sic] seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. When coming on duty... c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. Before and after performing any invasive procedure (e.g., fingerstick blood sampling)... l. Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident)... v. After removing gloves or aprons; and w. After completing duty." 3.1-18(a) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00284455. Nursing Home Complaint IN00284455-Substantiated. Federal/State deficiency related to the allegations are cited at F-689 and F-690.	R 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and**	

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	Survey dates: January 22, 23, 24, 25, 28, 29, 30, & 31 2019. Facility number: 000445 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 8, 2019		**other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the			

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	current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure 1 of 12 employees reviewed for annual resident rights inservice education had this education conducted. (LPN 13) Findings included: During the review of the personnel files on 1-31-19 at 2:00 p.m., LPN 13's file indicated a lack of resident rights inservice education for 2018 or 2019. In an interview with the Administrator on 1-31-19 at 5:05 p.m., she indicated LPN 13 did not receive any type residents rights inservice education for 2018 or to the current date. On 1-31-19 at 5:04 p.m., the Clinical Support Nurse provided a copy of a policy entitled, "Inservice Education." This undated policy was identified as the current policy utilized by the facility. This policy indicated, " Ongoing Training: All employees will be required to complete a minimum of two (2) courses each month in the "[Corporate] University On-Line Learning System. Courses will be assigned in the following subject matters throughout the year: Resident Rights..." 5.1.4(e)	R 0120	**R120 410IAC 16.2-51.4(e0(1-3)** **Personal Noncompliance** **I. LPN 13 has received resident rights education.** **II. All licensed residential residents have the potential to be affected by the alleged deficient practice. All Licensed residential employees have been reviewed to determine their Residents Rights training is up to date.** **III. Education will be provided to the Human Resource Director related to ensuring Resident Rights education is completed upon hire and annually. The systemic change will include an audit tool to be used upon hire and with annual employment dates to determine Resident Rights inservicing is completed. This audit tool will be kept in the employee file.**	03/01/2019

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			IV. The Human Resources Director will audit all newly hired employees during orientation to ensure their Resident Rights inservicing is completed in orientation. In addition, the Human Resources Director will audit all Licensed Residential Employees with their annual anniversary date to determine their resident rights training is completed. This auditing will be ongoing. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **COMPLIANCE DATE: March 1, 2019**	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the			

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	date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure 3 of 12 employees reviewed for tuberculosis screening had annual tuberculin screening conducted. (Unit Manager, LPN 7 and LPN 13) Findings include:	R 0121	**R121 410 IAC 16.2-5-1.4(f)(1-4)** **Personal Noncompliance** **I. Unit Manger, LPN 7 and LPN 13 have had their annual Tuberculin screening**	03/01/2019

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	During the review of the personnel files on 1-31-19 at 2:00 p.m., the files of the Unit Manager, LPN 7 and LPN 13 indicated a lack of current tuberculosis screening as follows: - the Unit Manager's most recent tuberculosis screening was identified as occurring on 3-17-17 via the "Employee 2nd Step & Annual PPD Record," provided by the Clinical Support Nurse on 1-31-19 at 4:50 p.m. - LPN 7's most recent tuberculosis screening was identified as occurring on 10-23-17 via the "Employee 2nd Step & Annual PPD Record," provided by the Clinical Support Nurse on 1-31-19 at 4:50 p.m. - LPN 13's most recent tuberculosis screening was identified as occurring on 10-8-17 via the "Employee 2nd Step & Annual PPD Record," provided by the Clinical Support Nurse on 1-31-19 at 4:50 p.m. In an interview with the Administrator on 1-31-19 at 5:05 p.m., she indicated the Unit Manager, LPN 7 and LPN 13 did not receive any type of tuberculosis screening for 2018 or to the current date. On 1-31-19 at 5:04 p.m., the Clinical Support Nurse provided a copy of a policy entitled, "Tuberculosis Infection Control Program," and identified as the current policy utilized by the facility, but undated. This policy indicated, "[Name of facility corporation] recognizes that tuberculosis (TB) transmission has been identified as a risk in healthcare settings. To try to prevent nosocomial transmission of TB, our facilities have instituted a Tuberculosis Infection Control Program. The following are guidelines for persons affiliated with and working within [corporate] facilities. This includes, but is not limited to,		**conducted.** **II. All licensed residential residents have the potential to be affected by the alleged deficient practice. All Licensed residential employees have been reviewed to determine their annual Tuberculin screening is completed.** **III. Education will be provided to the Human Resource Director related to ensuring tuberculin screening is completed upon hire and annually. The systemic change will include an audit tool to be used upon hire and with annual anniversary dates to determine annual tuberculin screening is completed. This audit tool will be kept in the employee file.** **IV. The Human Resources Director will audit all newly hired employees during orientation to ensure their tuberculin screening is completed in orientation. In addition, the Human Resources Director will audit all Licensed Residential Employees with their annual anniversary date to determine their tuberculin screening is completed. This auditing will be ongoing. Results of these audits will be reviewed at the**	

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	155481	A. BUILDING 00 B. WING	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	facility employees...An annual TB risk assessment (TBRA) and TB risk classification..." 5.1.4(f)(1)		**monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: March 1, 2019**	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to ensure over the counter (OTC) medications were properly labeled for 2 of 5 residents observed during 1 of 4 medication pass observations with 1 staff member. (Resident R2 and R6) Findings include: 1. During 1 of 4 medication pass observations on 1-31-19 at 11:50 a.m., with LPN 13, she was observed to obtain an OTC bottle of acetaminophen 500 milligrams (mg) for Resident R2. LPN 13 was observed to obtain 2 capsules of this medication for the resident. The bottle of acetaminophen 500 mg was observed to have a	R 0300	**R300 410 IAC 16.2-5-6 (c)(4) Pharmaceutical Services-Deficiency** **I. Resident R2 and Resident R6 have their own separate bottles of Acetaminophen and Complete Multi vitamin. Both are labeled correctly.** **II. All residents who use OTC medications have the potential to be affected by the alleged deficient practice. All residents with OTC medications have**	03/01/2019

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	facility label obscuring the manufacturer's label for the medications directions for use and potential side effects, with the facility label having hand-written information of the resident's last name and room number only. There was a lack of the prescribing physician's name on the bottle. In an interview with LPN 13 on 1-31-19 at 11:52 a.m., she indicated she was not sure what information was to be included on an OTC medication bottle. She indicated the facility uses the same bottle of acetaminophen 500 mg for Resident R-2's spouse, who is also a resident at the facility, as well both residents utilize the same bottle of a multi-vitamin for administration. LPN 13 obtained a bottle of Complete Multi-Vitamin which had had a facility label in place with hand-written information of each resident's last name, which was the same, with directions to administer one tablet daily. There was a lack of the prescribing physician's name on the bottle. Review of the 1-19 Medication Administration record for Resident R2 indicated physician's orders for acetaminophen 500 mg two tablets to total 1000 mg three times daily by mouth, ordered 8-16-18, and for one multi-vitamin daily by mouth, ordered on 4-21-18. 2. During 1 of 4 medication pass observations on 1-31-19 at 11:52 a.m., with LPN 13, she was observed to obtain an OTC bottle of acetaminophen 500 milligrams (mg) for Resident R6. LPN 13 was observed to obtain 2 capsules of this medication for the resident. The bottle of acetaminophen 500 mg was observed to have a facility label obscuring the manufacturer's label for the medications directions for use and potential side effects, with the facility label having hand-written information of the resident's last		**been reviewed to determine they have an individual supply of medications and the bottles are labeled appropriately.** **III. Education will be provided to the Assisted Living Nurses related to correctly labeling of medications and that each resident has their own supply of medications. The systemic change includes education to all licensed Assisted Living Nurses on correct labeling of medications and having an individual supply of medications for each resident.** **IV. The DON/Designee will audit OTC medications on Assisted Living to determine each resident has their own supply and they are correctly labeled. This auditing will occur daily for 4 weeks; then, monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Compliance Date: March 1, 2019**	

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	name and room number only. There was a lack of the prescribing physician's name on the bottle. In an interview with LPN 13 on 1-31-19 at 11:52 a.m., she indicated she was not sure what information was to be included on an OTC medication bottle. She indicated the facility uses the same bottle of acetaminophen 500 mg for Resident R-6's spouse, who is also a resident at the facility, as well both residents utilize the same bottle of a multi-vitamin for administration. LPN 13 obtained a bottle of Complete Multi-Vitamin which had had a facility label in place with hand-written information of each resident's last name, which was the same, with directions to administer one tablet daily. There was a lack of the prescribing physician's name on the bottle. Review of the 1-19 Medication Administration record for Resident R6 indicated physician's orders for acetaminophen 500 mg two tablets to total 1000 mg three times daily by mouth, ordered 8-16-18, and for one multi-vitamin daily by mouth, to be taken with food, ordered on 4-17-18. In an interview with RN 2 on 1-31-19 at 2:00 p.m., she indicated the facility does not have any particular policy regarding medication labeling for the residential portion of the facility, but does follow the state regulations for this. 5-6(c)(4)			