DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155206	A. BUILDING 00 B. WING	09/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00268603. Complaint IN00268603 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 22, 23, 24, 27, 28, 31, and September 4, 2018. Facility number: 000113 Provider number: 155206 AIM number: 100287670 Census Bed Type: SNF/NF: 79 SNF: 3 Total: 82 Census Payor Type: Medicare: 12 Medicaid: 53 Other: 17 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on September 07, 2018.	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Brownsburg Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Brownsburg Healthcare asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's credible allegation of compliance. Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action.	

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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			These do not necessarily chronologically correspond to the date that Brownsburg Healthcare is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			
	Based on record review and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for dental status for 1 of 1 resident reviewed for dental services (Resident 58). Findings include: Resident 58's record was reviewed on 8/24/18 at 11:40 a.m. An admission assessment, dated 7/5/18, indicated the resident did not have her own teeth and had dentures. A comprehensive MDS assessment, dated 7/12/18, indicated the resident was not edentulous (had natural teeth or tooth fragments). During an interview, on 8/24/18 at 11:52 a.m., Resident 58 indicated she was edentulous (had no natural teeth). During an interview, on 8/24/18 at 11:54 a.m., Certified Nursing Assistant (CNA) 26 indicated the resident did not have any teeth. During an interview, on 8/24/18 at 3:37 p.m., the MDS Coordinator indicated the comprehensive	F 0641	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #58's comprehensive MDS assessment was revised to indicate she was edentulous. A complete audit of the MDS's was conducted by DON to ensure compliance. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents who are edentulous have the potential to be affected by the alleged deficient practice. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not*	09/25/2018

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	MDS assessment, dated 7/12/18, was coded incorrectly and should had indicated the resident was edentulous. A copy of section L of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Assessment Coordinator on 8/24/18 at 3:00 p.m. Review of the manual indicated, "...L0200: Dental...Coding instructions...Check L0200b, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth...." 3.1-31(d)		*recur?* The MDS Coordinators were in-serviced on the policy to ensure accuracy of comprehensive assessments. MDS Coordinator will review comprehensive assessments on residents who are edentulous in the facility. Audits will be conducted for 3 months and quarterly for 3 quarters by DON or designee *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.			

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	§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to assess a resident for a pre-admission screening and resident review (PASRR) level 2 evaluation for 1 of 1 resident reviewed for PASARR level 2 evaluations (Resident 34). Findings include: On 08/22/18 at 3:43 p.m., Resident 34's record was reviewed. The record indicated the resident had diagnoses on admission, in December of 2016, which included, but were not limited to: anxiety disorder, major depressive disorder, and an eating disorder. Additional diagnoses were added after admission of delusional disorders on 2/10/17, and the disorder of severe psychotic features on 2/17/17. A significant change Minimum Data Set (MDS) assessment, dated 6/23/18, indicated the resident had diagnoses including but not limited to: anxiety, depression, and psychotic disorder. The significant change MDS assessment indicated no pre -admission screening and resident review (PASRR) level 2 evaluation had been completed. A form titled, "PAS (Ascend)," dated 12/20/16, indicated the resident did not have a serious mental illness as of December 2016, and a level 2 PASRR was not required at that time. During an interview, on 8/24/18 at 10:21 a.m., the Social Service Director (SS Director) indicated there was no level 2 PASRR for Resident 34. The resident had a psychiatrist and psychologist and	F 0644	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #34's PASSR level 2 evaluation was requested by the Social Services Director on 8/24/18. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* Residents who are eligible for a PASSR level 2 evaluation have the potential to be affected by the alleged deficient practice. A complete audit was conducted to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The Social Services Director has been in-serviced on the procedure regarding PASSR level 2 evaluations. The Social Services	09/25/2018

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	they checked with her regularly, but the PASRR level 2 was never completed for her with the new diagnoses or significant change MDS assessment. During an interview, on 8/24/18 at 3:38 p.m., the SS Director indicated the resident was not re-evaluated for a PASRR level 2 after her new diagnoses were added on 2/17/17, and she should have been re-evaluated. She indicated the facility did not have a policy for PASRRs and the facility followed the Ascend manual. Review of the Ascend manual, titled, "Indiana PASRR Level 1 & Level of Care Screening Procedures for Long-Term Care Provider Manual," with a revision date of 9/19/16, indicated, "...For residents of a Medicaid-certified nursing facility who have experienced a significant change in mental status that suggests the need for a first-time Level I review, a subsequent Level I review, or updated PASRR Level II evaluation...Examples of a mental status change event include...A new mental health diagnosis that is not listed on previous/initial LI [level 1] or Level II...."		Director reviewed resident charts who have been identified as needing a level 2 PASSR review. Audits will be conducted for 3 months and quarterly for 3 quarters by DON or designee. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for the use of the anti-coagulant medication for 1 of 5 residents reviewed for unnecessary medications (Resident 53).	F 0656	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #53's care plan was updated to include the use of anticoagulant medication as indicated by the physician order.	09/25/2018

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	Findings include: On 8/22/18 at 10:00 a.m., Resident 53 was observed. She was sitting in a wheelchair and slowly shuffled her feet to propel. She was not able to use her right arm to help propel the wheelchair, because the arm was observed resting on a padded tray. Her arm was observed to be significantly swollen, and the skin of her arm and fingers were discolored with various depths of purple, black, gray, and green. When interviewed, at that time, Resident 53 could not recall what had happened to her arm, just that it was doing much better, and did not hurt as bad. In an interview with UM 10, on 8/22/18 at 10:06 a.m., she indicated she did not know how Resident 53's arm came to be so badly discolored and swollen. Resident 53 had been fine on the evening shift, but woke up this morning with bad swelling. She was sent to the ER (emergency room) and when the Resident returned, told the UM 10 the ER doctor told her it was due to her use of Xarelto (a blood thinning medication). A medical record review for Resident 53 was completed on 8/24/18 at 01:06 p.m. A most recent comprehensive assessment was an Admission Minimum Data Set (MDS) assessment, dated 7/16/18. The MDS indicated Resident 53 was admitted on 7/6/18, from the community with active diagnosis to include but were not limited to: Dementia, chronic atrial fibrillation (an irregular heartbeat that causes poor blood flow), high blood pressure and heart failure, and had received anticoagulant medications in the 7 days prior to the assessment. Resident 53 was assessed as moderately cognitively impaired.		*2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents who are given anticoagulant medication have the potential to be affected by the alleged deficient practice. A complete audit of residents who are given anticoagulation medication was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* MDS Coordinators were in-serviced on the policy regarding care plans. Audits of resident care plans will be conducted by DON or designee upon admission and with quarterly care plan and prn with changes of care to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	Admitting physician orders included but were not limited to: Xarelto 15 mg (milligrams) 1 time daily. A Baseline Care Plan for Resident 53 was completed on 7/6/18 at 5:00 p.m. The assessment and Care Plan did not note Resident 53's history and current use of an anticoagulant medication. The complete Comprehensive Care Plan did not include documentation of Resident 53's historical and current use of an anticoagulant medication. The Medication Administration Record (MAR) for the month of July 2018, indicated Resident 53 received her scheduled dose of Xarelto 15 mg on July 6th-July 19th. A nursing progress note, dated 8/18/18 at 6:27 a.m., indicated, "... Res. [Resident] (L) [left] forearm is swollen and bruised, res. doesn't recall what happened, c/o [complaint of] discomfort...." A nursing progress note, dated 8/18/18 at 8:24 a.m., indicated, "... pt [patient] right arm cold to touch, blue/purple bruise, +3 swelling...." A nursing progress note, dated 8/18/18 at 6:28 p.m.. indicated, "... Resident return from ER at 4:45 p.m. via ambulance, with new order... a change of torsemide (a diuretic used to treat fluid retention) from 10 mg to 20 mg for 3 days, then resume the 10 mg Xarelto on hold for 4 days and no use of walker w/c [wheelchair] only...." A nursing progress note, dated 8/19/18 at 1:00 a.m., indicated, "... purple discoloration of right elbow to had continues, resident states she is unsure how it occurred, and that the MD said sometimes people on blood thinners just have blood vessels pop...."			

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On 8/20/18, Resident 53 was seen by the Nurse Practitioner who's progress note indicated, "... chief complaint: follow-up ER visit from 8/18/18.... upper right extremity bruising and swelling. Diagnosis right upper extremity acute hematoma [bruise] and acute CHF [congestive heart failure]...."

On 8/24/18 at 1:06 p.m., in an interview with the Director of Nursing (DON) and MDS Coordinator (MDSC), the DON indicated the facility did not know what caused the severe bruising on Resident 53's arm. ER staff concluded the bruising and swelling was caused by a broken blood vessel and the Resident's use of a blood thinning medication caused the bruise. The MDSC indicated the baseline care plan was incorrect because it did not indicate the use of anticoagulant medication, and because it was not on the baseline care plan, it got missed being put into the 14-day comprehensive care plan. The DON indicated, a care plan should have been created and put into place regarding Resident 53's acute hematoma due to her use of an anticoagulant medication.

A copy of a current facility policy titled, "Care Plans- Baseline" dated, 12/2016, indicated, "... A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission... the interdisciplinary team will review the healthcare practitioner's orders...including but not limited to: physician orders...." A second current facility policy titled, "Care Planing- Interdisciplinary Team" dated, 09/2013, indicated, "...our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each

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	resident... a comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)... the interdisciplinary team must review and update the care plan:... when the resident has been readmitted to the facility from a hospital stay..." 3.1-35(a)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to ensure physician's orders were followed for an antianxiety medication for 1 of 5 residents reviewed for psychotropic medications (Resident 76). Findings include: Resident 76's record was reviewed on 8/23/18 at 10:40 a.m. Diagnoses from the resident's profile included, but were not limited to, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A physician's order, start date 3/14/18, indicated Ativan (antianxiety medication) 0.5 milligrams (mg), give 0.5 mg by mouth at bedtime. A Medication Administration Record (MAR), dated July 2018, indicated the resident received Ativan 0.5 mg by mouth at bedtime for anxiety	F 0659	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* 1 LPN and 2 QMAs were given a written warning regarding improper documentation, and were re-educated on the proper procedure for documentation of anti-anxiety medication. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents who are given an antianxiety medication have the potential to be affected by the alleged deficient practice. A complete audit of residents who are given an antianxiety	09/25/2018

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	disorder. A controlled substance accountability sheet, dated July 2018, indicated Ativan 0.25 mg was administered on 7/17/18 at 8:30 p.m., 7/24/18 at 8:30 p.m., and 7/29/18 at 8:00 p.m. The document lacked documentation the physician's order of Ativan 0.5 mg was administered as ordered by the physician on 7/17/18, 7/24/18, and 7/29/18. A current care plan indicated the resident used an antianxiety mediation related to an anxiety disorder. An intervention included, but was not limited to, administer antianxiety medications as ordered by the physician. During an interview, on 8/24/18 at 2:00 p.m., the Director of Nursing (DON) indicated physician's orders should have been followed. On 8/24/18 at 2:00 p.m., the Director of Nursing (DON) provided an undated policy, "Administration Procedures For All Medications," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy: To administer medications in a safe and effective manner...After administration...document administration in the MAR or TAR, and controlled substance sign out record...." On 8/27/18 at 1:23 p.m., the DON provided an undated policy, "Care Plans, Comprehensive Person-Centered," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented		medication was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* All nursing staff was in-serviced on the correct procedure to document medication administration in the resident charts. Audits will be completed by DON or designee to monitor compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	for each resident...." 3.1-35(g)(2)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(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, record review, and interview, the facility failed to ensure a low air loss mattress was in place for a resident with an unstageable pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident 80). Findings include: During an observation, on 8/27/18 at 9:59 a.m., Resident 80 was observed laying in bed. No low air loss mattress was observed on the resident's bed. Resident 80's record was reviewed on 8/27/18 at 9:22 a.m. Diagnoses from the resident's profile included, but were not limited to, pressure ulcer to right buttock (start date 8/10/18) unstageable (full thickness tissue loss in which the base of the	F 0686	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #80's bed had a low air loss mattress placed per the physician order. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents who have an order for a low air loss mattress have the potential to be affected by the alleged deficient practice. A complete audit of residents who	09/25/2018

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	ulcer is covered by slough and/or eschar in the wound bed). A physician's order, dated 8/10/18, indicated low air loss mattress, check every shift. A current care plan indicated the resident had an unstageable pressure ulcer on her right buttock. Interventions included, but were not limited to, the resident required a pressure relieving mattress (low air loss mattress) on the bed. A Nurse Practioner (NP) progress note, dated 8/24/18, indicated the resident's wound had markedly worsened today. The resident's low air loss bed was being replaced today due to a malfunction. A Medication Administration Record (MAR), dated August 2018, for implementation of low air loss mattress indicated on 8/24/18 and 8/25/18, to see progress notes. A progress note, dated 8/25/18, indicated low air loss mattress not on bed. The MAR, dated August 2018, lacked documentation the air loss mattress was in place on evening shifts dated 8/12/18, 8/13/18, 8/20/18, 8/24/18 and day shifts dated 8/23/18 and 8/26/18. During an interview, on 8/27/18 at 11:10 a.m., the Assistant Director of Nursing (ADON) indicated the Nurse Practioner (NP) had noted on 8/24/18, the low air loss mattress was not functioning. The low air loss mattress was removed from the resident's bed on 8/24/18, had not been replaced until 8/27/18, and should had been replaced on 8/24/18. They had access to low air loss mattresses in the storage room at the facility and it was an error that it had not been replaced. On 8/24/18 at 2:00 p.m., the Director of Nursing		have an order for a low air loss mattress was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff was in-serviced on the procedure of carrying out physician orders on the placement of low air loss mattresses. Ongoing audits will be conducted by DON or designee to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	(DON) provided an undated policy, "Administration Procedures For All Medications," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy: To administer medications in a safe and effective manner...After administration...document administration in the MAR or TAR, and controlled substance sign out record...." On 8/27/18 at 1:23 p.m., the DON provided an untitled policy, "Care Plans, Comprehensive Person-Centered," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...." 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility			

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	receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, interview, and record review, the facility failed to assess and implement services for a contracture for 1 of 1 resident reviewed for limited range of motion (Resident 41). Findings include: During an observation, on 8/22/18 at 11:16 a.m., Resident 41 was lying on her back in bed. Her left hand was curved on top of her chest in the shape of the letter C. No brace was observed on the resident's left hand or arm. During an observation, on 8/23/18 at 2:14 p.m., Resident 41 was lying in bed on her back. Her left hand was on her chest and her fingers were curved in the shape of a C. During an observation, on 8/24/18 10:39 a.m., Resident 41's left hand was on her chest which was curved in the shape of C on her chest. On 8/23/18 at 2:43 p.m., Resident 41's record was reviewed. Diagnoses included but were not limited to: muscle weakness, vascular dementia with behavioral disturbance, diabetes type 2, severe protein-calorie malnutrition, abnormal weight loss, and pressure ulcer of sacral region stage 3 (Full-thickness loss of skin, in which fat is visible in the ulcer and granulation tissue are often present). A quarterly Minimum Data Set (MDS) assessment, dated 6/30/18, indicated Resident 41 had severe impaired cognition, unclear speech,	F 0688	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #41's care plan was updated to include range of motion exercises for the contracture on both hands. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents with contractures have the potential to be affected by the alleged deficient practice. A complete audit was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff was in-serviced on identifying contractures and, if necessary, to add interventions to the resident care plan. Ongoing audits will be conducted by DON or designee to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through	09/25/2018

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	and was an extensive assist of two or more people for bed mobility and transfer. The MDS indicated the resident had no functional limitation in range of motion in her wrists or hands. Care plans, dated 9/19/17 and current as of 8/23/18, included, but were not limited to: "Restorative Passive Range of Motion: potential for further decline in ROM in legs and ankles." Interventions: "PROM to bilateral hips...knee...ankle...provide program 6 days of week as resident will allow..." No documentation of a decline in range of motion or contractures for the resident's hands or arms was observed. During an interview, on 8/24/18 at 11:04 a.m., Unit Manager (UM) 29 indicated Resident 41 had a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the left hand. During an interview, on 8/24/18 at 2:45 p.m., Certified Nurse Aide (CNA) 31 indicated the resident's hand did not move and remained in the shape of a letter C. During an interview, on 8/27/18 at 10:29 a.m., the Director of Nursing (DON) indicated she was unable to find documentation of Resident 41's left hand contracture. She indicated there were no nursing or therapy assessments, or care plans related to the contracture. On 8/27/18 at 1:20 p.m. the DON provided a policy titled, "Restorative Nursing Services," with a revision date of July 2017, and indicated it was the current policy. Review of the policy indicated, "...Residents will receive restorative nursing care as needed to help promote optimal safety and		QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	independence...Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services...." 3.1-42(a)(2)			
F 0689 SS=E 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 ensure a safe environment for the secure memory care area (Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 72, 76, 86, and 137). This had the potential to effect 16 of 16 residents who reside on the memory care unit of 83 resident who reside in the facility. The facility failed to ensure fall interventions for 1 of 2 residents reviewed for falls (Resident 70). Findings include: 1.A. During a Memory Care unit observation, on 8/22/18 from 9:50 a.m. to 10:23 a.m., the findings in the resident rooms are as follows: a. Room 601-W (window) had a container of Tranquil Breeze powder on the bedside table. b. Room 602-W had an 18 ounce container of Vaseline on a bedside table, near the foot of the	F 0689	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* All toiletry items (lotions, razors, deodorant, powder, etc.) were removed from the resident rooms and placed into individual bins identifying them by room number. The bins have been placed behind a locked door for resident safety. The foot pedals in room 606-W have been removed from the resident's closet. The curling iron from room 604-D was removed from the resident's room. The electrical cord for an electric razor in 607-W was removed from the resident's room. The Director of Nursing also called each resident's family	09/25/2018

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	bed. c. Room 603-D (door) had a container of Ban deodorant and toothpaste. d. Room 604-D had a shower tote of one container each of Herbal Essence mousse (hair product), Glade aerosol air freshener, Active dry mouth fluoride mouth wash. A second shower tote had one container each of Big Sexy hair spray, Pink Himalayan Salt shampoo, Secret deodorant, Nivea shower lotion, Cherry Blossom body spray, Keratin shampoo and Biotin shampoo. e. Room 605-W had an 18 ounce container of Vaseline and Avon Instant shower gel. f. Room 607-W had 8 double-bladed safety razors with no blade guards, 2 small cuticles scissors, 3 nail clippers, and 2 metal tweezers in the top drawer. Aloe Vera skin lotion, Gold Bond body lotion, and Power Stick aerosol body spray were on top of the dresser. g. Room 609-W had a container of Dermasil dry skin treatment (skin lotion) on the dresser. During an interview, on 8/22/18 at 10:26 a.m., Licensed Practical Nurse (LPN) 6, Unit Manager of the Memory Care unit, indicated all chemicals should have been locked up. Things like shampoo, because the residents could have swallowed it. The residents wander and open drawers and closets. There should not have been aerosols in resident rooms because they would have put anything in their mouths, spray another resident, or put it in their own eyes. Tweezers and nail clippers should have been locked up. No razors should have been out, the residents could have cut themselves. Residents should have had electric razors. Anything the resident could have gotten their hands on, they could have put in their mouths, including the powder. Vaseline should not have been left in the rooms because the staff use it on the resident's bottoms, and putting it in		member/responsible party to inform them of the removal and storage of the items in the resident rooms. All call light cords were removed from the dementia care unit to prevent potential hazards. The call light plugs were also removed to prevent a choke hazard. Resident #70's bedside mats have been placed and a pool noodle was placed on each side of the resident's bed, and her bed is placed in the low position per physician order. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents have the potential to be affected by the deficient practice. A complete audit of resident rooms was conducted by DON or designee to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff have been in-serviced on the removal of items in resident rooms that could potentially be ingested. Also, letters were written to the responsible parties of the residents requesting that such items not be placed in the resident rooms, but to be given to	

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	their mouths would not have been good. During an observation, on 8/22/18 at 10:34 a.m., LPN 6 removed 8 double-bladed safety razors with no blades guards, 2 small cuticles scissors, 3 nail clippers, and 2 metal tweezers from Resident 30's top drawer. During an interview, on 8/22/18 at 10:38 a.m., LPN 6 indicated we had residents that would have tried to eat their napkins. During an interview, on 8/22/18 at 10:48 a.m., LPN 6 indicated Resident 72 should not have had deodorant, toothpaste or Wet Ones anti-bacterial hand wipes. During an interview, on 8/22/18 at 10:49 a.m., LPN 6 indicated Resident 6 should not have had shower totes with Big Sexy hair spray, Pink Himalayan Salt body wash, Secret deodorant, Nivea shower lotion, Cherry Blossom body spray, Keratin shampoo, or Biotin shampoo. During a Memory Care unit observation and interview, on 8/22/18 at 10:55 a.m., under the sink in the dining / activity room, there was Pure air freshener, and a glass vase, and beside the sink was a table knife. Ten residents were in the room, no staff were present until LPN 6 walked in. She indicated these items should not have been here. During a Memory Care unit observation, on 8/23/18 from 8:36 a.m. to 9:19 a.m., the findings were as follows: a. Room 607-W had Vaseline Cocoa Radiant skin lotion, Suave 2 in 1 shampoo, Aloe Vera skin lotion, Gold Bond body lotion, and Power Stick aerosol body spray were on top of the dresser. b. Room 608-D had 2 solid air fresheners on top of		the nurse at the nurse's station for safe storage. Audits will be conducted daily for 4 weeks, 3 times a week for 3 weeks, twice weekly for two weeks, weekly for one week, and random thereafter by DON or designee to ensure compliance. The CNA sheet was updated to show the placement of bedside mats and pool noodles for resident #70. Audits will be conducted by DON or designee to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	the over the bed light and 1 solid air freshener on top of the closet. c. In a shared bathroom, between Rooms 603 and 604, Japanese Cherry Blossom body lotion, and Kiwi Magic shampoo and body wash was found. d. In a shared bathroom, between Rooms 605 and 606, Avon Instinct shower gel was found. e. In the bathroom for Room 609, there was Curel Daily Healing lotion, Med Spa hand and body lotion, Med Spa deodorant, and skin repair cream. During a Memory Care unit observation and interview, on 8/23/18 from 9:29 to 9:34 a.m., the findings were as follows: a. LPN 6 indicated Avon Instinct shower gel should not have been in the Resident's shared bathroom between Rooms 605 and 606. She removed it and locked it up. b. LPN 6 indicated Japanese Cherry Blossom body lotion, and Kiwi Magic shampoo and body wash should not have been in the bathroom between Rooms 603 and 604. She disposed of the products because there were no resident names on them. c. LPN 6 indicated the solid air fresheners on top of the over the bed light and 1 solid air freshener on top of the closet should not have been in Room 608 and she threw them into the resident trash can. d. LPN 6 indicated the Curel Daily Healing lotion, Med Spa hand and body lotion, Med Spa deodorant, and skin repair cream should not have been in the room and all products should have been removed. e. LPN 6 indicated Vaseline Cocoa Radiant skin lotion, Suave 2 in 1 shampoo, Aloe Vera skin lotion, Gold Bond body lotion, and Power Stick aerosol body spray should not have been in Room 607-W, and locked them up. During an interview, on 8/23/18 at 9:45 a.m., LPN 6			

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indicated she should have gone through all the resident drawers and she should have removed any bottles that should not be there.

During a Memory Care unit observation, on 8/23/18 at 11:38 a.m., Odoban Spray Eliminates Odors was found in Room 607-W in the closet.

During an interview, on 8/23/18 at 11:44 a.m., LPN 6 indicated the Odoban Spray Eliminates Odors should not have been in Room 607.

During a Memory Care unit observation, on 8/23/18 at 11:47 a.m., acetone nail polish remover was found in a purse in the second drawer of Resident 36's beside table.

During an interview, on 8/23/18 at 11:50 a.m., LPN 6 indicated the acetone nail polish remover should not have been in the resident's room because a resident could have swallowed it.

During a Memory Care unit observation, on 8/23/18 at 11:51 a.m., a metal rat-tooth comb and a piece of jewelry with a stick pin on the back on it was found in Resident 35's top drawer of the dresser.

During an interview, on 8/23/18 at 11:56 a.m., LPN 6 indicated the rat-tooth comb could have been used as a weapon and the piece of jewelry with the stick pin could have been used to stab another resident or stab the staff.

During a Memory Care unit observation, on 8/23/18 from 12:16 p.m. to 12:32 p.m., the findings were as follows:
a. Room 604-W had 2 metal and plastic wheelchair foot pedal attachments on top of the closet.
b. Room 604-W had a nail kit with mirror, metal file,

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small scissors, and metal cuticle pusher in 4th drawer of dresser.
c. Room 609-D had Med Spa shaving cream, PhytoPlex anti-fungal ointment, hand lotion, nail clippers and Calmoseptine ointment in top drawer of bedside table. Also, had phone cord and q-tips, a small bin with office supplies: sharpies, pens, highlighters, small stapler, and tape in top drawer.
d. Room 603-D had Med Spa roll on deodorant in top drawer of bedside table.
e. Room 603-W had Mary Kay Satin Hand lotion in top drawer of bedside table.
f. Room 602-D had part of a broken drawer handle or picture frame in small table.
g. Room 602-W had Med Spa roll on deodorant, and Sparkle fresh mouth wash in the second drawer of the dresser.

During a Memory Care unit observation and interview, on 8/23/18 from 12:39 p.m. to 12:47 p.m., the findings were as follows:
a. LPN 6 indicated the 2 metal and plastic wheelchair foot pedal attachments on top of the closet in Room 604-W could have been used as a weapon because some of the residents get very agitated. She had CNA 7 remove them.
b. LPN 6 indicated the nail kit with mirror, metal file, small scissors, and metal cuticle pusher in 4th drawer of dresser in Room 604-W should not have been there. She removed it.
c. LPN 6 indicated the Med Spa shaving cream, PhytoPlex anti-fungal ointment, hand lotion, nail clippers, Calmoseptine ointment, phone cord, q-tips, and a small bin with office supplies: sharpies, pens, highlighters, small stapler, and tape should not have been in the top drawer. She removed everything.
d. LPN 6 indicated the Med Spa roll on deodorant should not have been in the bedside table in Room 603-D. It should not have been in the

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	Resident room. e. LPN 6 indicated the Mary Kay Satin Hands lotion in top drawer of bedside table of Room 603-W should not have been there and she removed it. f. LPN 6 indicated there was a part of a broken picture frame in a small table in Room 602-D. She indicated it should not have been there and removed it. g. LPN 6 indicated the Med Spa roll on deodorant, and Sparkle fresh mouth wash in the second drawer of the dresser in Room 602-W should not have been there and removed it. During a Memory Care unit observation and interview, on 8/27/18 from 10:58 a.m. to 11:08 a.m., the findings were as follows: a. Room 604-D had a curling iron in the second drawer of the dresser. LPN 6 indicated it should not have been there and removed it. b. Room 606-W had a metal and plastic wheelchair foot pedal attachments on top of the closet. LPN 6 indicated it should not have been there and removed it. c. Room 607-W had a cord for an electric razor in the top drawer of the bedside table. LPN 6 indicated it should not have been there and removed it. The memory care unit's Resident's cognitive statuses were provided by the Licensed Social Worker (LSW) on 8/28/18 at 9:30 a.m. It indicated the following information: a. Resident 76's cognition was severely impaired. b. Resident 49's cognition was severely impaired. c. Resident 29's cognition was severely impaired. d. Resident 9's cognition was severely impaired. e. Resident 72's cognition was severely impaired. f. Resident 86's cognition was severely impaired. g. Resident 6's cognition was severely impaired.			

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h. Resident 57's cognition was severely impaired.
i. Resident 137's cognition was severely impaired.
j. Resident 35's cognition was severely impaired.
k. Resident 36's cognition was severely impaired.
l. Resident 30's cognition was severely impaired.
m. Resident 65's cognition was severely impaired.
n. Resident 61's cognition was severely impaired.
o. Resident 21's cognition was severely impaired.
p. Resident 11's cognition was severely impaired.

On 8/24/18 at 3:39 p.m., the Administrator provided Material Safety Data Sheets (MSDS) for 14 of 34 products and substances found in the memory care area. The first aid and hazard product information follows:
a. The facility provided a non-acetone nail polish remover MSDS sheet. The product found in resident 606-W's room was an acetone nail polish remover. During an observation on 8/24/18 at 2:52 p.m., Certified Nursing Aide (CNA) 15 confirmed it was Equate Acetone Nail Polish Remover. The Centers for Disease Control (CDC) website indicated for acute hazards, " ...Inhalation: sore throat, cough, confusion, headache, dizziness, drowsiness, unconsciousness. Eyes: redness, pain, blurred vision, possible corneal damage. Ingestion: nausea and vomiting."
b. For Sparkle mouth wash, if, " ...ingested give plenty of water to dilute stomach contents. Do not induce vomiting. Seek immediate medical attention."
c. For Skin Repair cream, for eye contact, "flush with water, get medical attention if irritancy persists ...for ingestion get medical attention."
d. For Calmoseptine ointment, for ingestion " ...seek professional assistance or contact a poison control center immediately."
e. For PhytoPlex Antifungal ointment, for eye contact " ...flush with large amounts of water for at least 15 minutes while holding eyelids open. Get

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	immediate medical attention." f. For Med Spa shaving cream, for eye contact " ...flush eyes with large amount of water for at least 15 minutes. If irritation persists, seek medical attention. For inhalation, remove to fresh air. If not breathing, give artificial respiration. For ingestion, in swallowed, call a physician immediately. Do not induce vomiting unless direct to do so by a physician." g. For Degree deodorant stick, for eye contact " ...rinse thoroughly with water. For ingestion, do not induce vomiting. Drink a glass of milk or water." h. For Vaseline petroleum jelly, for eye contact immediately " ...flush eyes with plenty of water. For ingestion wash out mouth with water. Remove victim to fresh air. If material has been swallowed and the exposed person is conscious, give small quantities of water to drink. Do not induce vomiting." i. For Med Spa hand and body lotion, for ingestion " ...do not induce vomiting. Consult physician. Eyes: flush eyes with water for 15 minutes Consult physician." j. For Curel hand and body lotion, for ingestion " ...do not induce vomiting. Consult physician. Eyes: flush eyes with water for 15 minutes Consult physician." k. For Dermasil, ...harmful if swallowed ...risk of serious damage to eyes." l. For Wet Ones anti-bacterial wipes, for eyes " ...may cause irritation." m. For Keratin shampoo, for eyes " ...Immediately flush eyes with plenty of water for 15 minutes ...Ingestion: Wash mouth out and drink plenty of water." n. For Biotin shampoo, for eyes " ...Immediately flush eyes with plenty of water for at least 15 minutes ...Ingestion: Do not induce vomiting unless directed to do so by medical personnel."			

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o. For fluoride mouthwash, for eyes " ...may produce transient superficial irritation ...Ingestion: ingestion of large amounts may produce signs of stomach irritation."

On 8/24/18 at 3:39 p.m., the Administrator was unable to provide Material Safety Data Sheets (MSDS) for 20 of 34 products and substances found in the memory care area. They are listed:
a. Herbal Essence shampoo
b. Glade aerosol air freshener
c. Big Sexy hairspray
d. Pink Himalayan Salt shampoo
e. Secret deodorant
f. Nivea shower lotion
g. Cherry blossom body spray
h. Pure air freshener
i. Avon Instant shower gel
j. Tranquil Breeze powder
k. Suave 2 in 1 shampoo
l. Aloe Vera skin lotion
m. Mary Kay Satin Hands lotion
n. Odoban Spray Eliminates Odors
o. Power Stick Intensity aerosol
p. Kiwi Magic shampoo and body wash
q. Solid air freshener
r. Vaseline Cocoa Radiant skin lotion
s. Gold Bond skin lotion

During an interview, on 8/27/18 at 8:15 a.m., the Director of Nursing (DON) indicated and provided nursing notes, dated 8/25/18, for all the families of the memory care residents. The nursing notes indicated (family member name), "notified that cannot keep any potentially harmful items in (his/her) room, agreeable."

During an interview, on 8/27/18 at 2:41 p.m., LPN 6 indicated the residents who actively wandered were: Residents 76, 49, 29, 6, 137, 36, 65, and 11.

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The resident who hit or push other residents or staff were Residents 76, 49, 9, 6, 65, 21, 57, 30, 21, 86, and 11.

During an interview, on 8/24/18 at 10:27 a.m., the DON indicated the facility policy was memory care residents were to have no harmful products or substances in their room. This would have included scissors, razors, shampoos, deodorants, and nail clippers.

A current policy, titled, "Accident Free Environment," dated 3/14/17, was provided by LPN 10 on 8/24/18 at 1:00 p.m. Review of the policy indicated, "All resident are to be kept safe at all times. This includes hazardous materials such as lotions, powders, soap, perfumes, and anything that can be ingested. All sharp materials and instruments are not to be kept in resident rooms, such as knitting needles, tweezers, scissors, etc. Any medical supply instruments and cleaning supplies are not to be left in resident rooms."

1.B. During a memory care observation, on 8/22/18 at 10:09 a.m., Resident 30's call light was on the floor under the privacy curtain. The resident was in bed.

During an interview, on 8/22/18 at 10:39 a.m., LPN 6 indicated the facility had one memory care resident who pulled out call lights and wound them up and put them in a drawer. If a resident is in bed, the call light should still be there where they can reach it, even if they cannot understand how to use it. She had not noticed Resident 30's call light on the floor, and he should have had it on the bed.

During a memory care observation, on 8/23/18 at

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	8:31 a.m., Resident 36's call light was on the floor. The resident was in bed. During an interview, on 8/23/18 at 9:36 a.m., LPN 6 indicated Resident 36 should have had the call light on the bed. During an observation, on 8/24/18 at 10:49, the call lights for all the resident rooms were as follows: a. Room 601-D had a call light clipped to the bed, the resident was not in the room. b. Room 601-W did not have a call light in the room. The resident was in the recliner with eyes closed. c. Room 602-D had a call light clipped to the privacy curtain in the resident's reach. The resident was in bed with eyes closed. d. Room 602-W had a call light clipped to the bed, the resident was not in the room. e. Room 603-D did not have a call light. The resident was not in the room. f. Room 603-W had a call light laid across the over the bed table not in reach of the resident. The resident was in bed with eyes closed. g. Room 604-D had a call light clipped to the bed, the resident was not in the room. h. Room 604-W did not have a call light, resident was not in the room. i. Room 605-D had a call light clipped to the bed, the resident was not in the room. j. Room 605-W had a call light clipped to the bed, the resident was not in the room. k. Room 606-W had a call light clipped to the bed in reach of the resident. The resident was in bed with eyes closed. l. Room 607-W had a call light on the floor under the privacy curtain. The resident was in bed. m. Room 608-D had a call light clipped to the bed, the resident was not in the room. n. Room 608-W had a call light clipped to the bed,			

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	the resident was not in the room. o. Room 609-D had a call light clipped to the bed, the resident was not in the room. p. Room 609-W had a call light clipped to the bed, the resident was not in the room. During an interview, on 8/24/18 at 11:03 a.m., LPN 6 indicated the call lights in the memory care room could have been a risk because a call light could have been used as a weapon and none of the residents press the call light intentionally. During an observation, on 8/24/18 at 2:49 p.m., the call lights had been removed from resident rooms. Six rooms had call light cords cut off of the call light plug-ins. The call light plugs were still plugged into the walls in Rooms 603, 604, 605, 607, 608, and 609. During an interview, on 8/24/18 at 2:54 p.m., LPN 6 indicated the call light plugs should not have been in the wall of the memory care resident's rooms because they represented a swallowing hazard. During an interview, on 8/24/18 at 2:59 p.m., the Maintenance man (MM) indicated he is very new and he cut the cords off of the call light plugs, but did not recognize the call light plugs as a swallowing hazard. During an interview, on 8/24/18 at 10:35 a.m., the DON indicated there should not have been any call lights in the memory care unit at all, and they should have been unplugged from the walls and removed. The residents could have tripped or gotten tangled up in them. Staff were supposed to be either in the dining room with the residents or in the hall watching the residents. Checks on residents in bed should have been at least every 2			

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hours.

A policy, titled, "Answering Call Light," dated October 2010, was provided by LPN 10 on 8/24/18 at 1:00 p.m. It indicated, " ...Some residents may not be able to use their call light. Be sure you check these residents frequently.

2. On 8/22/18 at 12:02 p.m., Resident 70 was observed in bed with bilateral lower extremities amputated from above the knees. Resident 70 was twisting back and forth in bed struggling to get up. She called out when she saw a person in hallway. No side rails, mats, or pillows were observed around the resident, and the call light was on the floor.

On 8/22/18 at 10:30 a.m., Unit Manager 29 provided the Certified Nurse Aide (CNA) Assignment Sheet. The assignment sheet indicated Resident 70 was a bilateral amputee and required total assistance. The CNA sheet did not list any fall interventions which should be provided for the resident.

Observation on 8/23/18 at 8:23 a.m., the resident was in bed with her eyes closed. No side rails, mats, pillows, or equipment to prevent rolling out of bed were observed.

Observation on 8/23/18 at 9:38 a.m., the resident was in bed with no side rails, no pool noodles, and no mats on the floor. The call light was observed on the floor. Resident 70 had unclear speech and was unable to answer questions.

Observation on 8/23/18 at 11:40 a.m., the resident was lying in bed with her eyes open and the call light was at the end of the bed. No side rails or pool noodles or mats were observed.

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Observation on 8/23/18 at 2:11 p.m., the resident was in bed on her back. The call light was next to her. No side rails or pool noodles or mats were observed.

Observation on 8/24/18 at 11:15 a.m., Resident 70 was up in her wheelchair in her room watching television. No side rails or pool noodles or mats were observed near her bed.

Observation on 8/27/18 at 10:36 a.m., no floor mats or pool noodles were observed in Resident 70's room.

On 8/23/18 at 9:33 a.m., Resident 70's record was reviewed. Medical diagnoses included, but were not limited to: acquired absence of left leg above knee, unspecified lack of coordination, muscle weakness, acquired absence of right leg above knee, phantom limb syndrome with pain, anxiety disorder.

An admission summary, dated 6/4/18 at 11:50 p.m., indicated the resident arrived by stretcher from the hospital. She was post amputation of bilateral legs above the knees. She was alert and oriented at times.

A Health Status Note, dated 6/13/18 at 4:37 p.m., indicated the resident had fallen out of her wheelchair by leaning forward and had a skin tear on her left forearm.

A Health Status Note, dated 6/14/18, at 12:06 a.m., indicated, "CNA found resident sitting on the floor on top of blanket. Resident had cigarette in mouth. Resident assisted x 2 [by 2 staff] back in bed. Bed placed in lowest position...."

A Health Status Note, dated 6/14/18 at 6:00 a.m.,

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indicated the resident was checked frequently for signs of unsafe movements.

Physician orders, with a start date of 6/14/18, included, but were not limited to: "...Resident is a fall risk: Floor mats both sides of bed when resident is in bed...bed in lowest position when resident is in bed...Pool noodles both sides of the bed as reminder to request assistance prior to transferring...."

A Health Status Note, dated 6/15/18 at 4:58 a.m., indicated the resident was grabbing the side rail and attempting to pull herself onto the floor.

A Health Status Note, dated 6/16/18 at 8:02 p.m., indicated, "Resident found trying to scoot out of her chair, when asked what she is doing she said I need to get of here. It's time to go school (sic). Resident helped from chair to bed. She immediately tried to scoot out of bed and throw her self on the floor. She stated I need to get up. Staff said okay we can get you back in your chair she said no I need to get up and go to school. Staff tried to explain that with her amputation we only had 2 options right now. She continued to be agitated talking about going to school. Writer told that she would be back in a few minutes to see which she wanted to do and resident stated that was fine and that she wouldn't try to get up without help. Aid came on got writer a couple of minutes later stating that resident was on the floor. Resident assisted to bed, assessed for injury and vitals taken...."

A significant change Minimum Data Set (MDS) assessment, dated 7/2/18, indicated the resident had severely impaired cognition per a staff interview, adequate hearing, no speech, was rarely understood, and rarely understood others. The

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resident required an extensive assist of 1 person for bed mobility, locomotion, eating, toilet use, and personal hygiene. The resident required an extensive assistance of 2 people for dressing and transfers.

A Fall screener assessment, dated 8/22/18, indicated the resident had three or more falls in the last three months and was a high risk for falls.

An incident note, dated 8/22/18 at 6:15 p.m., indicated, "...resident laying on floor next to bed on her right side. Body check done. ROM [range of motion], denies pain. superficial scratch, 0.2 cm [centimeters] to right stump. No active bleeding...Assisted up and back into bed. Resident stated she was reaching for a cup of water on her table and fell out of bed. [doctor's name] and niece notified."

Resident 70's current care plan, updated on 8/22/18, indicated, "...risk for falls r/t [related to] (B) [bilateral] AKA [above knee amputation], potential for adverse side effects of meds [medications], confusion unaware of own safety limits, 2 falls on 6/13/18. 8/22/18 at 6 pm found on floor beside bed unable to state what she was doing. Goal: ...resident will be free of injury through the review date...Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed...Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs...keep her personal items within reach...Mat on floor on both sides of bed, noodles on both sides bed in lowest position when in bed...."

During an interview, on 8/24/18 at 2:41 p.m., Certified Nursing Assistant (CNA) 31 indicated

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	Resident 70 had no special fall precautions like pillows or side rails. Resident 70 was observed in bed on her back with her eyes closed. No side rails, pool noodles, mats, or pillows were observed. During an interview, on 8/27/18 at 10:56 a.m., Unit Manager (UM) 29 indicated Resident 70 was to have fall mats on both sides of her bed and pool noodles in her bed. She had not seen them in her room since she was moved to her new room. Approximately two weeks prior the resident was moved to a new room due to air conditioner issues in the 400 hall. The floor mats and pool noodles were in place in her old room on 400 hall and the orders were still in place. UM 29 indicated the mats and the pool noodles did not get moved to her new room. During an interview, on 8/27/18 at 11:31 a.m., the Assistant Director of Nursing indicated UM 29 had informed her of Resident 70's missing fall interventions. They were now in place and should have been there. Staff were to follow physician orders and plans of care and the fall precautions should have been in place prior to and after her last fall on 8/22/18. On 8/27/18 at 11:37 a.m., the MDS Coordinator, provided the policy titled, "Accidents and Incidents-Investigating and Reporting," with a revision date of July 2017, and indicated it was current. Review of the policy did not specify following physician orders or plan of care. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0744 SS=E	483.40(b)(3) Treatment/Service for Dementia			

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Bldg. 00	§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure there was a qualified dementia care director and a qualified activity director for the memory care residents. This deficient practice had the potential to effect 16 of 16 residents reviewed for dementia care (Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 72, 76, 86, and 137). Findings include: 1. During an interview, on 8/27/18 at 1:48 p.m., Licensed Social Worker (LSW) and designated Dementia Care Director indicated she was not the Dementia Care Director (DCD). During an interview, on 8/27/18 at 1:57 p.m., the Administrator indicated the Director of Nursing recalled the LSW was designated as the DCD by the former Administrator 1. During an interview, on 8/27/18 at 2:06 p.m., the LSW indicated she did not know she was the DCD. She had never worked as the DCD and did not oversee the day to day dementia care operations. During an interview, on 8/27/18 at 2:20 p.m., the Administrator indicated no one was designated as the DCD prior to the LSW, but someone should have been the DCD to oversee the day to day operations. As of today, the Administrator was going to take over care of the dementia care unit.	F 0744	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* The Administrator has been designated as the director of the facility's Alzheimer unit. Additionally, the Activities Director has been hired and began working at the facility on 8/29/18. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents in the dementia care unit have the potential to be affected by the deficient practice. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The Administrator, who was hired on 8/21/18, will have 12 hours of dementia-specific training. She will oversee the operation of the unit. Additionally, the Activities Director will have 12 hours of dementia-specific training within 90 days of her hire date. The Activity Director has developed a resident-centered activity calendar	09/25/2018

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	During an interview, on 8/27/18 at 2:35 p.m., the Assistant Director of Nursing (ADON) indicated she did not know how long the facility had gone without a DCD. During an interview, on 8/27/18 at 2:38 p.m., the Administrator indicated she was a Certified Dementia Care Provider through the National Organization of Certified Dementia Care Practitioners. During an interview, on 8/27/18 at 2:41 p.m., LPN 6 indicated the residents who actively wandered were: Residents 6, 11, 29, 36, 49, 65, 76, and 137. The resident who hit or push other residents or staff were Residents 6, 9, 11, 21, 30, 49, 57, 76, and 86. During an interview, on 8/27/18 at 2:53 p.m., Licensed Practical Nurse (LPN) 6 indicated she was the Unit Manager of the dementia care unit and the DON was her supervisor. If the DON was not there, she would go to the ADON. She had worked here for four months and no one had told her the LSW was the Dementia Care Director. During an interview, on 8/27/18 at 2:58 p.m., the DON indicated the former Administrator 2 told her that the LSW was the Dementia Care Director about 2 or 3 months ago. The dementia care Unit Manager had only called her for nursing issues only. The DON indicated she was never the Dementia Care Director. During an interview, on 8/27/18 at 3:06 p.m., the Human Resources Director (HRD) indicated the LSW was the DCD. During an interview, on 8/27/18 at 3:31 p.m., the		designed for residents with dementia. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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HRD indicated the previous DCD was not the former Administrator 2, but the administrator prior to that one. The former Administrator 3 was the last DCD, and she left the facility in March 2017.

During an interview, on 8/28/18 at 9:17 a.m., the LSW indicated during the 2-3 months she was the designated DCD, she did not complete 12 hours of dementia care training, she never specifically worked in that department, and did not have 1 year of dementia work experience.

The memory care unit's Resident's cognitive statuses were provided by the Licensed Social Worker (LSW) on 8/28/18 at 9:30 a.m. It indicated the following information:
a. Resident 76's cognition was severely impaired.
b. Resident 49's cognition was severely impaired.
c. Resident 29's cognition was severely impaired.
d. Resident 9's cognition was severely impaired.
e. Resident 72's cognition was severely impaired.
f. Resident 86's cognition was severely impaired.
g. Resident 6's cognition was severely impaired.
h. Resident 57's cognition was severely impaired.
i. Resident 137's cognition was severely impaired.
j. Resident 35's cognition was severely impaired.
k. Resident 36's cognition was severely impaired.
l. Resident 30's cognition was severely impaired.
m. Resident 65's cognition was severely impaired.
n. Resident 61's cognition was severely impaired.
o. Resident 21's cognition was severely impaired.
p. Resident 11's cognition was severely impaired.

During an interview, on 8/28/18 at 10:02 a.m., the Administrator indicated the facility did not have a policy regarding a dementia care director. She was working with (name of local hospital), since we did not have a dementia care program for 16 of 16 resident residing in memory care.

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2. During an interview, on 8/28/18 at 11:21 a.m., Activity Aide (AA) 35 indicated she was the only person who worked in the activity department. We are staff challenged. The previous Activity Director left on 7/23/18, but printed an activity calendar for this month. She had been able to keep up with the calendar pretty well, but with changes. People from other departments cover the activities as they can when she was off work. No one is doing the dementia care unit. The Certified Nurse Aides (CNA) were doing the activities with the memory care residents. The dementia care area residents get stimulation, but some days are better than others. I cannot vouch for a lot of coverage in memory care, it's something they needed to do sooner, rather than later.

During an interview, on 8/28/18 at 10:19 a.m., Licensed Practical Nurse (LPN) 6 indicated there were no activity logs (documentation in the computer for residents completing activities) for Residents 9, 30, 11, and 49.

During an interview, on 8/28/18 at 11:02 a.m., LPN 6 indicated there is no activity person for the dementia care unit. They have had one off and on. Resident 30 did not have any desires for activities, but sometimes would have gone outside with them. Resident 11 liked to sit in Resident 76's room and listen to music, and would have gone outside sometimes. Resident 9 liked to get her hair done, and on Friday's her friend came and sometime took her to a music program. Resident 49 is difficult, sometimes she would have gotten her nails done, and her husband would have taken her out for a Coke. The activities that had been provided have been doing their nails, listening to music, read to them, take them outside on the enclosed patio, provide baby dolls, plastic bowling pin game, and for a few memory care

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residents, play cards or listening to music in the main facility.

During an interview, on 8/28/18 at 11:15 a.m., LPN 6 indicated we had a musician in here on 8/23/18.

During an interview, on 8/27/18 at 2:41 p.m., LPN 6 indicated the residents who actively wandered were: Residents 6, 11, 29, 36, 49, 65, 76, and 137. The resident who hit or push other residents or staff were Residents 6, 9, 11, 21, 30, 49, 57, 76, and 86.

A current care plan was provided for Resident 72, on 8/28/18 at 10:20 a.m., by the Assistant Nursing Director (ADON). Resident 72's admission date was 7/24/18. The activity care plan, in part, reads, "Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary.

Current activity care plans for the dementia care unit residents were provided on 8/28/18 at 10:20 a.m. by the Assistant Nursing Director (ADON). They were not dated. These interventions were provided for 2 for more memory care residents and were not person centered, and individualized. They included Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 76, and 86. The information was as follows:
a. Assist resident with personal mail (as needed).
b. Call resident by name and touch gently on the arm to refocus on the tasks or procedures at hand.
c. Encourage small or individual or group activities, on/off unit.
d. Invite resident outside in nice weather for fresh air, socialization, enjoyment since that was important.
e. Keep a conscientious balance between

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	residents needs for both stimulation and relaxation. f. Let resident doze if best indicators are that resident is more tired than usual or if resident has been reawakened too many times. g. Monitor resident of s/s (signs and symptoms) of irritability and calmly assist to a less stimulating area as needed. h. Offer optimal seating amongst compatible resident if possible. i. Offer volunteer visits for resident to have opportunities for conversing and individual attention. j. Provide beauty shop for self-enhancement and sensory stimulation (or manicure) k. Provide simple, clear directions for tasks within residents abilities. l. Resident may attend/participate in any activity of interest. (on and off unit as tolerated) m. Support the value of the family's interaction with resident and re-evaluate care plan if the level of their involvement should change. n. Will respect resident's right to refuse. o. Provide pet therapy for opportunities for a loving touch. p. Guide residents hands describe program and offer tactile olfactory, auditory, visual, gustatory opportunities with programs. q. Furnish resident with own personal activity calendar and explain options. r. Encourage resident to participate in activities such as group games for stimulation of procedural memory. (Resident 30, 35, and 36) s. Encourage resident to watch TV in the dining room for a change in environment and some socialization with peers and staff. t. Give resident occasional reminders before activity begins. u. Balance needs for stimulation and solace (relaxation).			

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Current activity care plans for the dementia care unit residents were provided, on 8/28/18 at 10:20 a.m., by the Assistant Nursing Director (ADON). They were not dated. Different intervention information was provided for Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 76, and 86 were as follows:
a. Bring activity cart in room for opportunities for reading materials/music of interest. (Resident specific information for Residents 6, 9, 11, 29, 30, 36, 49, 57, 61, 76, and 86).
b. Invite resident to OOR (out of room) activities that correspond to past interest (Resident specific information for Residents 11, 29, 30, 35, 57, 61, and 76).
c, Invite resident to special events/musicals/socials as a gentle nudge to "get out" once in a while (Resident specific information for Residents , 6, 11, 29, 61, 76, and 86).
d. Encourage resident to watch TV in the dining room for a change in environment and some socialization with peers and staff (Residents 61, 65, and 76).).
e. Adapt activities to residents limitations i.e. give visual demonstrations, etc. Especially target group recreational program which focus on residents long term memories and leisure pursuits (Resident 6).
f. Assist resident with country store visits/purchases, resident visits store frequently. Remind resident of the therapeutic value of group activities (Resident 21).
g. Offer resident items such as word searches, adult coloring pages, magazines and snacks for in room/dining room items of leisure pleasure. Provide sensory stimulation for relaxation, such as hand massages, aromatherapy, and tactile stimulation (Resident 35).
h. Offer brief stop by visits, always introducing

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self, and explain purpose of visit. Resident may have 2 alcoholic beverage a day in facility happy hour (Resident 36).
i. Offer to read devotionals/Bible scriptures to resident for continuation of faith and spiritual growth. Provide positive feedback on resident's accomplishments during activities/programs she participates in (Resident 49).
j. Provide communion through Eucharistic minister and invite to catholic mass/rosary for continuation of father and spiritual growth. Invite resident outside in nice weather for fresh air, socialization, enjoyment since that was important (Resident 61).
k. Provide pastoral visits for continuation of faith/comfort and spiritual growth. Observe/monitor residents interest/participation in activities, such as music, jigsaw puzzles, going outdoors (Resident 86)

During an interview, on 8/28/18 at 10:45 a.m., the Minimum Data Set (MDS) person indicated LPN 6 and a memory care aide represented the dementia care residents during Care Plan meetings. Sometimes family were involved, about 1/3 to 1/2 of the memory care families were involved with the residents. The Licensed Social Worker (LSW) would have tried to reach the family. A review of the census information provided upon entry indicated there were 16 residents in the memory care area.

During an interview, on 8/28/18 at 9:47 a.m., the Director of Nursing (DON) indicated the previous Activity Director quit about a month ago and the new activity director would have started tomorrow.

3.1-37(a)

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F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.			
	Based on record review and interview, the facility failed to ensure laboratory services were provided for 2 of 6 resident's reviewed for laboratory services (Resident 80 and Resident 76). Findings include: 1. Resident 80's record was reviewed on 8/27/18 at 9:22 a.m. Diagnoses from the resident's profile included, but were not limited to, deep vein thrombosis (DVT) (a blood clot in a deep vein). A lab result report, dated 8/16/18, indicated the resident's INR was high 4.4, reference range was 0.9-1.1. A lab result report, dated 8/20/18, indicated the resident's INR was high 7.1, reference range was 0.9-1.1. A lab result report, dated 8/24/18, indicated the resident's INR was high >10, reference range was 0.9-1.1. A physician's order, dated 8/24/18, indicated to obtain labs of a prothrombin time (PT)/ international normalized ratio (INR) (blood test that measured how long it took blood to clot) blood test on 8/25/18 and 8/27/18.	F 0770	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Resident #80 had a lab test administered on 8/27/18 to check her PT/INR, and the results of the lab were within normal limits. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents have the potential to be affected by the deficient practice. A complete audit of residents who have a physician order for blood work was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff has been in-serviced on the policy of physician orders. The Director of Nursing or	09/25/2018

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	A review of progress notes, dated 8/25/18, lacked documentation the lab had been obtained. A current care plan, reviewed on 8/27/18, indicated the resident was on anticoagulant therapy related to DVT. An intervention included, but was not limited to, labs as ordered. During an interview, on 8/27/18 at 11:47 a.m., the Assistant Director of Nursing indicated the resident had a critical PT/INR lab on 8/24/18 and had an order for a PT/INR to be redrawn on 8/25/18 and it was missed in error. She was unsure why it was missed 2. Resident 76's record was reviewed on 8/23/18 at 10:40 a.m. A physician's order, dated 5/15/18, indicated to obtain the following blood work, basic metabolic panel (BMP) (blood test used to check kidneys and electrolyte and acid/base balance, and blood glucose level), complete blood count(CBC) (blood test used to evaluate a wide range of disorders) with differential, thyroid stimulating hormone (TSH) (blood test used to check thyroid hormone), and Vitamin B12 level (blood test used to measure the amount of B12 in the blood) on 5/16/18. A lab result report, dated 5/16/18, indicated the resident was combative and lab would redraw on 5/17/18. A review of progress notes, dated 5/16/18, lacked documentation the physician was notified the labs were not obtained. A review of progress notes, dated 5/17/18, lacked documentation the labs were obtained and lacked documentation the physician was notified the labs		designee is auditing all labs for compliance. Night shift nurse supervisor is also auditing physician orders daily to identify possible missing labs. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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were not obtained.

During an interview, on 8/28/18 at 11:36 a.m., the Assistant Director of Nursing indicated she could not find documentation the labs were drawn on 5/17/18, a second attempt should have been attempted and the physician should have been notified the labs were not drawn as ordered.

On 8/24/18 at 12:57 p.m., the Unit Manager provided an undated policy, "Physician Notification," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy: Physicians to be notified of...changes in status, any emergent condition, abnormal labs...Notify MD immediately upon knowledge of any changes and document notification in resident record."

On 8/24/18 at 2:00 p.m., the Director of Nursing (DON) provided an undated policy, "Administration Procedures For All Medications," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy: To administer medications in a safe and effective manner...After administration...document administration in the MAR or TAR, and controlled substance sign out record...."

On 8/27/18 at 1:23 p.m., the DON provided an undated policy, "Care Plans, Comprehensive Person-Centered," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...."

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	3.1-49(a)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure hand washing was adequately performed during Memory Care lunch dining service, the Middle dining room lunch service, and in the kitchen. This deficient practice had the potential to effect 16 of 16 resident's dining in memory care, 11 of 11 resident's dining in the Middle dining room, and 83 of 83 residents served food from the kitchen. Findings include:	F 0812	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Both nursing and dietary staff have been in-serviced on proper handwashing techniques. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be*	09/25/2018

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	During an observation in the memory care unit dining room, on 8/22/18 at 12:04 p.m., Certified Nursing Aide (CNA) 7 washed her hands for 7 seconds and provided a lunch tray to Resident 29, without further hand washing, she provided to lunch tray to Resident 72. During an observation in the memory care unit dining room, on 8/22/18 at 12:11 p.m., Licensed Certified Nurse (LPN) 6 washed her hands for 11 seconds and provided a lunch tray to Resident 137. During an observation in the memory care unit dining room, on 8/22/18 at 12:13 p.m., CNA 7 washed her hands for 12 seconds and provided assistance with eating for Resident 29. During an observation, on 8/22/18 at 12:32 p.m., LPN 16 picked up a key ring with keys off of the floor of the Middle dining room floor, did not wash her hands, and opened Resident 66's carton of milk and cut up her lunch with the Resident's silverware. During a dining observation in the memory care unit dining room, on 8/23/18 at 11:58 a.m., LPN 6 completed a 7 second hand wash, then touched Resident 137's shoulder, with no further hand washing, LPN 6 touched Resident 76's shoulder. During a dining observation in the memory care unit dining room, on 8/23/18 at 12:03 p.m., CNA 18 provided lunch for Resident 36, then without hand washing, provided lunch for Resident 35. During a dining observation in the memory care unit dining room, on 8/23/18 at 12:09 p.m., LPN 6 completed a 7 second hand wash, then provided		*taken?* All residents have the potential to be affected by the deficient practice. A complete audit of staff was conducted by DON and Dietary Manager to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing and Dietary staff have been in-serviced on the correct procedure regarding handwashing. Audits will be conducted daily for 4 weeks, 3 times a week for 3 weeks, twice weekly for two weeks, weekly for one week, and random thereafter by DON or designee to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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	lunch for Resident 21. During an observation. on 8/27/18 at 11:16 a.m., the Dietary Manager, was in the kitchen, and lathered her hands for 12 seconds. During an observation. on 8/27/18 at 11:17 a.m., the Dietary aide 19, was in the kitchen, and lathered her hands for 15 seconds. During an observation, on 8/27/18 at 11:16 a.m., the Dietary aide 20, was in the kitchen, and lathered her hands for 13 seconds. During an interview, on 8/27/18 at 12:03 p.m., the Dietary Manager indicated hands should have been lathered for 30 seconds. If hands were visibly soiled, hands should have been lathered for 60 seconds. During an interview, on 8/24/18 at 10:37 a.m., the Director of Nursing (DON) indicated hand washing should have been 20 second lather. A current policy, titled, "Handwashing/Hand Hygiene," dated August 2015, was provided by the ADON on 8/27/18 at 2:10 p.m. A review of the policy indicated wash hands, " ...before and after direct contact with residents ...after contact with a resident's intact skin ...before and after eating or handling food ...before and after assisting a resident with meals ...Vigorously lather hands with soap ...for a minimum of 20 seconds." 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	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 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			

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	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 residents were screened for tuberculosis (TB) upon admission for 5 of 19 residents reviewed for tuberculosis screening (Residents 1, 13, 61, 76, and 80). The nurses had received a tuberculosis educational program for administering and reading TB screenings for 4 of 4 nurses reviewed for TB educational training. The facility failed to ensure proper storage of nebulizer equipment for 1 of 4 residents reviewed for respiratory care (Resident	F 0880	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Residents #1, 13, 61, 76, and 80 who did not receive a 2-step TB screening have now received them per facility policy. Resident #1's nebulizer tubing was replaced and properly stored and dated. LPN #32 was educated of the	09/25/2018

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	1). The facility failed to ensure staff wore gloves during an injection during medication administration for 1 of 3 residents reviewed for medication injection (Resident 388). Findings include: 1. During a record review, on 8/24/18 at 4:11 p.m., Resident 76 had a Step 1 TB screening (the first step of a two-step screening process to rule out tuberculosis). It was administer on 10/26/17, the results were negative. On 11/25/18, had a Step 2 TB screening (the second step of a two-step screening process to rule out tuberculosis) was administered by Licensed Practical Nurse (LPN) 32, the results were negative. During an interview, on 8/27/18 at 10:22 a.m., the Regional Consultant indicated it was 40 days between Resident 76's TB screenings. It should have been 1-3 weeks. During a record review, on 8/24/18 at 4:13 p.m., Resident 61 had a Step 1 TB screening. It was administered by LPN 12 on 9/12/17, the results were not posted. On 10/12/17, a chest x-ray was completed. The nursing notes indicated Resident 61, "had admission chest xray [sic] done at facility to rule out TB with findings of NAD (no active disease)." During an interview, on 8/27/18 at 10:38 a.m., the Regional Consultant indicated a Step 2 or chest x-ray should have been completed for Resident 61 in 1-3 weeks. During a record review, on 8/24/18 at 4:15 p.m., Resident 80 had a Step 1 TB screening. It was administered by LPN 21 on 7/24/18, the results were negative. On 8/3/18, had a Step 2 TB		proper use of gloves during the administration of an injectable medication. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents have the potential to be affected by the deficient practice. A complete audit was conducted on existing residents for the 2-step administration of TB screening. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff was in-serviced on the policy for the administration of TB testing for new residents. Audits will be conducted by DON or designee on new admissions to ensure compliance. Nursing staff was in-serviced on the proper storage of nebulizer tubing. Audits will be conducted daily for 4 weeks, 3 times a week for 3 weeks, twice weekly for two weeks, weekly for one week, and random thereafter by DON or designee to ensure compliance. Nursing staff was in-serviced on the procedure for administering injectable medication, including the use of gloves. Audits will be conducted daily for 4 weeks, 3 times a week for 3 weeks, twice	

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	screening administered by LPN 23, the results were not posted. During an interview, on 8/27/18 at 1:36 p.m., the Director of Nursing (DON) indicated she called LPN 23. She indicated there were no positive results for the TB screenings, so the DON put a negative response into the computer on 8/27/18. During a record review, on 8/28/18 at 12:02 p.m., Resident 13 was admitted on 2/9/18. The Step 1 TB screening was completed by LPN 23 on 2/27/18, the results were, "unable to determine." The Step 2 TB screening was completed by LPN 28 on 3/12/18, the results were negative. During a record review, on 8/28/18 at 12:13 p.m., Resident 1 was admitted on 8/2/18. The Step 1 TB screening was completed by LPN 23 on 8/19/18. Step 2 TB screening was completed on 3/12/18 by LPN 27, the results were negative. During an interview, on 8/24/18 at 10:39 a.m., the DON indicated for TB screenings, Step 1 should have been done on resident entrance (facility admission), Step 2 should have been completed 2 weeks later, and annuals should have been completed. During an interview, on 8/28/18 at 12:03 p.m., the DON indicated she was not able to find TB training for any of the nursing staff. Their (name of tracking software) was messed up. During an interview, on 8/28/18 at 12:42 p.m., the DON indicated she was not able to find any training for the nurses for TB. She had looked through everything. The previous Assistant Director of Nursing (ADON) left in February 2018 and left no documentation of TB education.		weekly for two weeks, weekly for one week, and random thereafter by DON or designee to ensure compliance. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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During an interview, on 8/28/18 at 12:46 p.m., the current ADON indicated she started in her present position in March 2018 and had not completed any staff training for TB, but some training information was in (name of tracking software).

During an interview, on 8/28/18 at 11:44 a.m., the Regional Nurse Consultant indicated the Indiana training requirements indicated it was no longer required for nurses to be certified. The facility did a training program here, but we did not certify our nurses.

An Indiana State Department of Health document, titled, "Tuberculin Skin Test Training Requirements," dated September 30, 2005, was provided by the Regional Consultant. It indicated, " ...Health Facilities Licensing and Operational Standards," 410 IAC 16.2-3.1-14(t) states " ...a tuberculin skin test ...administered by persons having documentation of training from a department-approved program ..."

A policy, titled, "Tuberculosis, Screening Residents for," dated July 2013, was provided by LPN 10 on 8/24/18 at 1:00 p.m. It indicated, " ...Any resident without documented negative TST (tuberculin skin test) ...or CXR (chest x-ray) within the previous 12 months will receive a baseline (two step) TST ...upon admission. If the first TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read. ...Screening of new admissions or readmissions for Tuberculosis infection and disease will be in compliance with State regulations."2. During an observation, on 8/22/18 at 2:00 p.m., Resident 1's nebulizer (a device used to administer medication in the form of a mist inhaled into the lungs) tubing and mask were

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	observed on the night stand, not covered with a plastic bag or dated. During an observation, on 8/23/18 at 9:38 a.m., Resident 1's nebulizer tubing and mask were observed on the night stand, not covered with a plastic bag or dated. During an observation, on 8/23/18 at 11:30 a.m., Resident 1's nebulizer tubing and mask were observed on the night stand, not covered with a plastic bag or dated. During an observation, on 8/23/18 at 1:53 p.m., Resident 1's nebulizer tubing and mask were observed on the night stand, not covered with a plastic bag or dated. Interview, on 8/24/18 at 1:08 p.m., the Director of Nursing (DON) indicated the nebulizer equipment mask should have been stored in a plastic bag when not being used and should have been dated with marker. Resident 1's record was reviewed on, 8/23/18 at 11:42 a.m. Diagnoses from the resident's profile included, but were not limited to, acute respiratory failure (impaired lung function that leads to decreased oxygen uptake and inadequate delivery of oxygen to the body's tissues), and heart failure (condition in which the heart does not pump blood as well as it should). The resident's medication administration record (MAR), dated August 2018, indicated the resident's medication regimen included, but was not limited to, Albuterol sulfate (a medication used to relax the airway) nebulization solution, inhale 1 vial orally via nebulizer four times a day for congestive heart failure (CHF) exacerbation.			

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The MAR indicated the medication was administered on 8/22/18, 8/23/18, and 8/24/18.

On 8/24/18 at 1:40 p.m., the Assistant Director of Nursing (ADON) provided an undated policy, "Nebulizer Kit Change," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "Policy: Every 72 hours the nebulizer kit and storage bag are to be changed. The new mask should be dated and the bag containing the neb kit should be dated with resident's last name."3. During a medication administration observation, on 8/28/18 at 7:44 am, Licensed Practical Nurse (LPN) 32 was observed to prepare medications for Resident 388 including but not limited to: Lovenox (anticoagulant) 40 milligrams (mg) per 0.4 milliliter (ml). At 7:50 a.m. after giving oral medications to the resident, LPN 32 indicated she was going to give the resident his Lovenox subcutaneous (applied under the skin) injection in the stomach. Without applying gloves, LPN 32 used an alcohol swap and cleaned Resident 388's stomach directly to the right of the belly button. She injected the Lovenox into the cleaned area of the stomach to the right of the belly button. She then applied another alcohol swap to the injection site and wiped the area again. During the observations LPN 32 did not wear gloves.

On 8/28/18 at 9:27 a.m., Resident 388's physician orders were reviewed and included, but was not limited to: Lovenox (anticoagulant) 40 milligrams (mg) per 0.4 milliliter (ml) daily for 5 days.

During an interview, on 8/28/18 at 10:04 a.m., the Director of Nursing (DON) indicated nurses should wear gloves when administering injections. The DON provided a policy titled, "Subcutaneous Injections," with a revision date

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	of March 2011, and indicated it was the current policy. Review of the policy indicated, "...The purpose of this procedure is to provide guidelines for the administration of medication by subcutaneous injection...Equipment and Supplies...Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed)...Perform hand antisepsis...Put on gloves...." 3.1-18(a) 3.1-18(e) 3.1-18(f) 3.1-18(h)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side			

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	effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure pneumococcal vaccines were provided in accordance to national recommendations for resident's greater than 65 years of age for 2 of 7 residents reviewed for pneumococcal vaccines (Resident 41 and Resident 15).	F 0883	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* A comprehensive review of all pneumococcal vaccine administration was conducted by the Director of Nursing. All	09/25/2018

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	Findings include: During an interview, on 8/27/18 at 2:26 p.m., the Director of Nursing (DON) indicated the facility had not implemented the Centers for Disease Control (CDC) recommendations for the 13-valent pneumococcal conjugate vaccine (PCV 13) and 23-valent pneumococcal conjugate vaccine (PPSV 23). She was not aware of the new CDC recommendations. During a review of the facility's pneumococcal immunizations, on 8/27/18 at 2:53 p.m., a document, titled "Pneumococcal Immunization," indicated adults 65 years or older who have not previously received PCV 13 and who have previously received one or more doses of PPSV 23 should receive a dose of PCV13. The dose of PCV 13 should be given at least 1 year after receipt of the most recent PPSV 23. Usually one dose of PPSV 23 is all that is needed. However, under some circumstances a second dose may be given. A second dose is recommended for those people aged 65 and older who got their first dose when were under 65 if 5 or more years have passed since that dose. The following resident's lacked documentation that pneumococcal immunization had been offered and education provided to give consent or refuse for the pneumococcal immunizations: a. Resident 41 was admitted to the facility on 4/22/14 and was greater than 65 years of age. A immunization report indicated the resident had a pneumonia vaccine during the fall of 2013. No documentation was found that the resident had been offered a pneumococcal immunization since admission. b. Resident 15 was admitted to the facility on		responsible parties of residents have given consent or refusal for 2018. Immunization records were updated on every resident from family records if they were not administered at the facility. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents have the potential to be affected by the deficient practice. A complete audit was conducted by DON to ensure compliance. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Nursing staff was in-serviced on the policy regarding pneumococcal vaccine administration. Current residents will receive their pneumococcal vaccinations according to the CDC recommendations, and new residents will be offered vaccination upon admission per facility policy. Audits will be conducted by DON or designee upon admission and annually thereafter. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through	

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	8/28/15 and was greater than 65 years of age. A immunization report indicated the resident had a pneumovax dose 1 on 3/16/16. No documentation was found that the resident had been offered the two step process. On 8/25/18 at 10:25 a.m., the Director of Nursing (DON) provided an untitled policy, "Vaccination of Residents," and indicated the policy was the one currently being used by the facility. Review of the policy indicated, 'Policy statement: All residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated or the resident has already been vaccinated. Policy interpretation and implementation: 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. (See current vaccine information statements at...cdc.gov...." 3.1-13(a)		QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum	F 9999	*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* The Administrator has been designated as the director of the facility's Alzheimer unit. Additionally, the Activities Director has been hired and began working at the facility on 8/29/18. *2. How will the facility identify other residents having the potential to be affected by the*	09/25/2018

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	of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. (x) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. This State rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the dementia care unit had a qualified dementia care director. This deficient practice had the potential to effect 16 of 16 memory care residents. Findings include: During an interview, on 8/27/18 at 1:48 p.m., Licensed Social Worker (LSW) and designated		*same alleged deficient practice and what corrective action will be taken?* All residents in the dementia unit have the potential to be affected by the deficient practice. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* The Administrator, who was hired on 8/21/18, will have 12 hours of dementia-specific training. She will oversee the operation of the unit. Additionally, the Activities Director will have 12 hours of dementia-specific training within 90 days of her hire date. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Facility will complete ongoing monitoring for compliance through QAPI and the monthly QA meeting. Committee will determine with results of the audit for continuance of monitoring.	

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Dementia Care Director indicated she was not the Dementia Care Director (DCD).

During an interview, on 8/27/18 at 1:57 p.m., the Administrator indicated the Director of Nursing recalled the LSW was designated as the DCD by the former Administrator 1.

During an interview, on 8/27/18 at 2:06 p.m., the LSW indicated she did not know she was the DCD. She had never worked as the DCD and did not oversee the day to day dementia care operations.

During an interview, on 8/27/18 at 2:20 p.m., the Administrator indicated no one was designated as the DCD prior to the LSW, but someone should have been the DCD to oversee the day to day operations. As of today, the Administrator was going to take over care of the dementia care unit.

During an interview, on 8/27/18 at 2:35 p.m., the Assistant Director of Nursing (ADON) indicated she did not know how long the facility had gone without a DCD.

During an interview, on 8/27/18 at 2:38 p.m., the Administrator indicated she was a Certified Dementia Care Provider through the National Organization of Certified Dementia Care Practitioners.

During an interview, on 8/27/18 at 2:53 p.m., Licensed Practical Nurse (LPN) 6 indicated she was the Unit Manager of the dementia care unit and the DON was her supervisor. If the DON was not there, she would go to the ADON. She had worked here for four months and no one had told her the LSW was the Dementia Care Director.

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During an interview, on 8/27/18 at 2:58 p.m., the DON indicated the former Administrator 2 told her that the LSW was the Dementia Care Director about 2 or 3 months ago. The dementia care Unit Manager had only called her for nursing issues only. The DON indicated she was never the Dementia Care Director.

During an interview, on 8/27/18 at 3:06 p.m., the Human Resources Director (HRD) indicated the LSW was the DCD.

During an interview, on 8/27/18 at 3:31 p.m., the HRD indicated the previous DCD was not the former Administrator 2, but the administrator prior to that one. The former Administrator 3 was the last DCD, and she left the facility in March 2017.

During an interview, on 8/28/18 at 9:17 a.m., the LSW indicated during the 2-3 months she was the designated DCD, she did not complete 12 hours of dementia care training, she never specifically worked in that department, and did not have 1 year of dementia work experience.

During an interview, on 8/27/18 at 2:41 p.m., LPN 6 indicated the residents who actively wandered were: Residents 6, 11, 29, 36, 49, 65, 76, and 137. The resident who hit or push other residents or staff were Residents 6, 9, 11, 21, 30, 49, 57, 76, and 86.

During an interview, on 8/28/18 at 10:02 a.m., the Administrator indicated the facility did not have a policy regarding a dementia care director. She was working with (name of local hospital), since we did not have a dementia care program. 3.1-14 PERSONNEL

(u) In addition to the required inservice hours in

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subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

This State rule was not met as evidenced by:

Based on record review and interview, the facility failed to provide state approved Dementia training for 3 of 10 employees reviewed for initial and annual Dementia training. This deficient practice had the potential to effect 16 of 16 residents residing on the locked Dementia unit.

Findings include:

On 8/27/18 at 3:00 p.m. employee files were reviewed.

CNA 30 and CNA 33 were both hired on 7/27/18. CNA 34 was hired on 8/8/18.

CNA 30, CNA 33, and CNA 34 were all signed in on an attendance sheet for having completed a 3 hour Dementia training conducted by the Assistant Director of Nursing (ADON). The material covered, and training content was noted as, "see attached." The attachment was a plot summary for the movie, "The Notebook."

On 8/27/18 at 3:41 p.m., in an interview with the ADON, she indicated she had provided the Dementia training for new employees. The 6 hours of initial dementia training included 3 hours of

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online training, 2 hours of watching the movie "The Notebook", and 1 hour discussing the movie. The ADON indicated the 3 hour attendance record for CNA 30, CNA 33 and CNA 34 was the attached "IMBD [Internet Movie Database] Plot Summary" of the movie, The Notebook. The ADON indicated the movie, The Notebook, provided a brief snapshot of Dementia, and helped facilitate discussion.

On 8/28/18 at 9:18 a.m., in an interview with CNA 30, she indicated she had not worked in the locked unit yet, but she had been given an initial tour of the locked unit and experienced it as scary and intimidating. She indicated the movie, "The Notebook" was not what to expect when she visited the locked unit.

On 8/28/18 at 12:41 p.m., in an interview with the Administrator, she indicated staff should be trained using state approved Dementia training materials, and the movie, "The Notebook" would not be included in further training.

On 8/28/18 at 1:56 p.m., in an interview with the Administrator, she indicated there was no specific policy addressing the facility's procedure for initial and annual Dementia training. She indicated the facility should follow state and federal regulations and provided copies of abuse, neglect, and exploitation regulation which indicated, "... all facilities must develop, implement and permanently maintain an effective training program for all staff, which includes... dementia training... for example staff training may be facilitated through any combination of in-person instruction, webinars and/or supervised practical training hours..."

3.1-33 ACTIVITIES

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	(a) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (b) The facility shall have a plan of activities appropriate to the needs of the residents of that facility that include, but is not limited to, the following: (1) Group social activities. (2) Indoor and outdoor activities, which may include daily walks. (3) Activities away from the facility. (4) Spiritual programs and attendance at houses of worship. (5) Opportunity for resident involvement in planning and implementation of the activities program. (6) Creative activities, such as the following: (A) Arts. (B) Crafts. (C) Music. (D) Drama. (E) Educational programs. (7) Exercise activities. (8) One (1) to one (1) attention. (9) Promotion of facility/community interaction. (c) An activities program shall be provided on a daily basis, including evenings and weekends. At least thirty (30) minutes of staff time shall be provided per resident per week for activities duties. Participation shall be encouraged, although the final option remains with the resident. (d) Responsibilities of the activities director shall include, but are not limited to, the following: (1) Preparing a monthly calendar of activities written in large print and posted in a prominent location that is visible to residents and visitors.			

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	(2) Assessing resident needs and developing resident activities goals for the written care plan. (3) Reviewing goals and progress notes. (4) Recruiting, training, and supervising volunteers when appropriate. (5) Coordinating the activities program with other services in the facility. (6) Requesting and maintaining equipment and supplies. (7) Participation in developing a budget. (e) The activities program must be directed by a qualified professional who: (1) is a qualified therapeutic recreation specialist or an activities professional, who is eligible for certification as a therapeutic recreational specialist or an activities professional by a recognized accrediting body on or after October 1, 1990; (2) has two (2) years of experience in a social or recreational program, approved by the department within the last five (5) years, one (1) of which was full time in a resident activities program in a health care setting; (3) is a qualified occupational therapist or occupational therapy assistant; or (4) has satisfactorily completed, or will complete within six (6) months, a ninety (90) hour training course approved by the division and has at least a high school diploma or its equivalent. Current employment as an activities director who completed an approved activities director course prior to the effective date of this rule shall be allowed to maintain a position as an activities director in health care facilities. (f) After July 1, 1984, any person who has not completed an activities director course approved by the division and is assigned responsibility for the activities program shall receive consultation until the person has completed such a course. Consultation shall be provided by: (1) a recreation therapist;			

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(2) an occupational therapist or occupational therapist assistant; or
(3) a person who has completed a division-approved course and has two (2) years' experience.

This State rule was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure there was a qualified activity director for the residents. This deficient practice had the potential to effect 83 of 83 residents.

Findings include:

During an interview, on 8/28/18 at 11:21 a.m., Activity aide (AA) 35 indicated she was the only person who worked in the activity department. We were staff challenged. The previous Activity Director left on 7/23/18, but printed an activity calendar for this month. She had been able to keep up with the calendar pretty well, but with changes. People from other departments covered the activities as they could when she was off work. No one was doing the dementia care unit. The Certified Nurse Aides (CNA) were doing the activities with the memory care residents. The dementia care area residents got stimulation, but some days were better than others. She could not vouch for a lot of coverage in memory care, it was something they needed to do sooner, rather than later.

During an interview, on 8/28/18 at 10:19 a.m., Licensed Practical Nurse (LPN) 6 indicated there were no activity logs (documentation in the computer for residents who had completed activities) for Residents 9, 30, 11, and 49.

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	During an interview, on 8/28/18 at 11:02 a.m., LPN 6 indicated there was no activity person for the dementia care unit. They have had one off and on. Resident 30 did not have any desires for activities, but sometimes would have gone outside with them. Resident 11 liked to sit in Resident 76's room and listened to music, and would have gone outside sometimes. Resident 9 liked to get her hair done, and on Friday's her friend came and sometime took her to a music program. Resident 49 was difficult, sometimes she would have gotten her nails done, and her husband would have taken her out for a Coke. The activities that had been provided had been doing their nails, listen to music, read to them, take them outside on the enclosed patio, provide baby dolls, plastic bowling pin game, and for a few memory care residents,they played cards or listened to music in the main facility. During an interview, on 8/28/18 at 11:15 a.m., LPN 6 indicated we had a musician in here on 8/23/18. During an interview, on 8/27/18 at 2:41 p.m., LPN 6 indicated the residents who actively wandered were: Residents 6, 11, 29, 36, 49, 65, 76, and 137. The resident who hit or push other residents or staff were Residents 6, 9, 11, 21, 30, 49, 57, 76, and 86. A current care plan was provided for Resident 72, on 8/28/18 at 10:20 a.m., by the Assistant Nursing Director (ADON). Resident 72's admission date was 7/24/18. The activity care plan, in part, reads, "Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Current activity care plans for the dementia care			

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	unit residents were provided, on 8/28/18 at 10:20 a.m., by the Assistant Nursing Director (ADON). They were not dated. These interventions were provided for 2 for more memory care residents and were not person centered, and individualized. They included Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 76, and 86. The information was as follows: a. Assist resident with personal mail (as needed). b. Call resident by name and touch gently on the arm to refocus on the tasks or procedures at hand. c. Encourage small or individual or group activities, on/off unit. d. Invite resident outside in nice weather for fresh air, socialization, enjoyment since that was important. e. Keep a conscientious balance between residents needs for both stimulation and relaxation. f. Let resident doze if best indicators are that resident is more tired than usual or if resident has been reawakened too many times. g. Monitor resident of s/s (signs and symptoms) of irritability and calmly assist to a less stimulating area as needed. h. Offer optimal seating amongst compatible resident if possible. i. Offer volunteer visits for resident to have opportunities for conversing and individual attention. j. Provide beauty shop for self-enhancement and sensory stimulation (or manicure) k. Provide simple, clear directions for tasks within residents abilities. l. Resident may attend/participate in any activity of interest. (on and off unit as tolerated) m. Support the value of the family's interaction with resident and re-evaluate care plan if the level of their involvement should change. n. Will respect residents right to refuse.			

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	o. Provide pet therapy for opportunities for a loving touch. p. Guide residents hands describe program and offer tactile olfactory, auditory, visual, gustatory opportunities with programs. q. Furnish resident with own personal activity calendar and explain options. r. Encourage resident to participate in activities such as group games for stimulation of procedural memory. (Resident 30, 35, and 36) s. Encourage resident to watch TV in the dining room for a change in environment and some socialization with peers and staff. t. Give resident occasional reminders before activity begins. u. Balance needs for stimulation and solace (relaxation). Current activity care plans for the dementia care unit residents were provided, on 8/28/18 at 10:20 a.m., by the Assistant Nursing Director (ADON). They were not dated. Different intervention information was provided for Residents 6, 9, 11, 21, 29, 30, 35, 36, 49, 57, 61, 65, 76, and 86 were as follows: a. Bring activity cart in room for opportunities for reading materials/music of interest. (Resident specific information for Residents 6, 9, 11, 29, 30, 36, 49, 57, 61, 76, and 86). b. Invite resident to OOR (out of room) activities that correspond to past interest (Resident specific information for Residents 11, 29, 30, 35, 57, 61, and 76). c. Invite resident to special events/musicals/socials as a gentle nudge to "get out" once in a while (Resident specific information for Residents , 6, 11, 29, 61, 76, and 86). d. Encourage resident to watch TV in the dining room for a change in environment and some socialization with peers and staff (Residents 61,			

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65, and 76).).
e. Adapt activities to residents limitations i.e. give visual demonstrations, etc. Especially target group recreational program which focus on residents long term memories and leisure pursuits (Resident 6).
f. Assist resident with country store visits/purchases, resident visits store frequently. Remind resident of the therapeutic value of group activities (Resident 21).
g. Offer resident items such as word searches, adult coloring pages, magazines and snacks for in room/dining room items of leisure pleasure. Provide sensory stimulation for relaxation, such as hand massages, aromatherapy, and tactile stimulation (Resident 35).
h. Offer brief stop by visits, always introducing self, and explain purpose of visit. Resident may have 2 alcoholic beverage a day in facility happy hour (Resident 36).
i. Offer to read devotionals/Bible scriptures to resident for continuation of faith and spiritual growth. Provide positive feedback on residents accomplishments during activities/programs she participates in (Resident 49).
j. Provide communion through Eucharistic minister and invite to catholic mass/rosary for continuation of father and spiritual growth. Invite resident outside in nice weather for fresh air, socialization, enjoyment since that was important (Resident 61).
k. Provide pastoral visits for continuation of faith/comfort and spiritual growth. Observe/monitor residents interest/participation in activities, such as music, jigsaw puzzles, going outdoors (Resident 86)

During an interview, on 8/28/18 at 10:45 a.m., the Minimum Data Set (MDS) person indicated LPN 6 and a memory care aide presented the dementia

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care residents during Care Plan meetings. Sometimes family were involved, about 1/3 to 1/2 of the memory care families were involved with the residents. The Licensed Social Worker (LSW) would have tried to reach the family. During an interview, on 8/28/18 at 9:47 a.m., the Director of Nursing (DON) indicated the previous Activity Director quit about a month ago and the new activity director would have started tomorrow.			