STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419550. Complaint IN00419550 --Federal/state deficiencies related to the allegations are cited at F656 and F689. Survey dates: October 30 and 31, 2023 Facility number: 000018 Provider number: 155053 AIM number: 100273930 Census Bed Type: SNF/NF: 37 Residential: 16 Total: 53 Census Payor Type: Medicare: 4 Medicaid: 23 Other: 10 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 3, 2023	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is November 27, 2023. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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			

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

Diana Gore | Administrator | 11/18/2023

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(iii) Be culturally-competent and trauma-informed. Based on observation, interview and record review, the facility failed to develop care plans related to the use of a wanderguard (safety device used as an audible alarm to notify staff of an exit or elopement attempt from a secured area) for 2 of 3 residents reviewed for the use of wanderguards. (Resident B and E) Findings include: 1. The clinical record of Resident B was reviewed on 10-30-23 at at 2:55 p.m. His diagnoses included, but were not limited to a history of traumatic brain injury (TBI), unspecified encephalopathy, viral hepatitis, falls and mild neurocognitive disorder. His most recent Minimum Data Set (MDS) assessment, dated 8-29-23, indicated he has moderate cognitive impairment, is ambulatory without use of an assistive device and did not indicate any wandering behaviors during the look-back period of the assessment. A review of Resident B's assessments for wandering and elopement reflected his admission assessment on 7-3-23 for wandering was a moderate risk, but he was not an elopement risk. Wandering risk assessments on 7-6-23 and 8-5-23 were unchanged. However, the next listed elopement risk assessment conducted on 10-26-23 identified him as a high risk. Multiple observations of Resident B confirmed he had a wanderguard placed onto his left ankle during the survey time. Resident B was identified by the facility as one of three current residents with a wanderguard alarm.	F 0656	**F656 Comprehensive Care Plans** It is the policy of this facility to develop care plans for residents at risk or have attempted to elope and wander guards. **What corrective action will be accomplished for residents affected?** For residents identified in this survey, care plans were updated by the MDS Coordinator on 10/31/23 with wander guard and elopement attempt made by Resident B. Their most recent elopement risk assessment has been reviewed and found to be appropriate. **How will other residents with potential to be affected be identified?** All residents have the potential to be affected. An audit was completed for residents with wander guards and at risk for elopement and care plans update as indicated by MDS coordinator/designee on 10/31/23. **Measures to be put in place to ensure practice does not recur:** Director of Nursing/designee will educate nurses to update care plan with new orders for wander guards and residents that attempt	11/27/2023

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	In an interview with the Executive Director (ED) on 10-30-23 at 3:58 p.m., she indicated Resident B had a wanderguard since she began employment on 8-28-23. "We just noticed that he did not have an official order on file for it until today when we were reviewing it. This is the only elopement we have had since I have been here." The ED indicated Resident B was near the facility's entrance on 9-29-23, when a pizza delivery person brought in a delivery. "He held the door open for him [Resident B] and the alarm was going off and the guy didn't even seem to notice it was going off. As soon as the resident got outside, he took off like the wind. No walker, no rollator, just flew! It took us about 2 minutes to catch up to him and get him turned around and brought back in the building. He was not out of sight at any point. When the delivery guy got back to the entry, he made a comment to the effect of, 'Oh, I guess I let that guy out.'" In a second interview with the ED on 10-31-23 at 11:25 a.m., she recalled Resident B received his wanderguard on the first or second day of her employment at the facility, when the facility's Nurse Practitioner (NP) wrote an order for it. "I just assumed that the nursing staff had inputted the order into the system, which of course, would have triggered the care plan and it getting put on the MAR [medication administration record] or TAR [treatment administration record] for the daily checks. Well, that didn't happen, until afterward. He did receive the wanderguard to wear at that time, but none of the rest of the things got done until recently. As a matter of fact, it was audited just right before you showed up, when my corporate person was here. I was very honest with her, I told her, just like I'm telling you, that I assumed all of those things got done, but you know what can happen when one assumes		to elope by 11/27/23, with emphasis on getting an order for use of device and checking placement and function every shift. Additionally, any employee who fails to comply with the points of the in-service may be further educated and / or progressively disciplined as indicated. Inservices will be completed by 11/27/23. **How will corrective action be monitored?** The Director of Nursing and/or designee will use the Exit Seeking Compliance Audit to audit each admission and re-admission to ensure an elopement risk assessment has been completed and if identified as an elopement risk, an order for a wander guard/check placement and function has been obtained, and the elopement risk is care planned. Any corrections needed will be made when found during the audit. This audit will occur for every admission and re-admission for a period of not less than 6 months. The DON and/or designee will present audit findings to the QAPI Committee at the monthly meeting. The QAPI Committee will review audit findings for a period of not less than 6 months and when compliance is 95% or better, the	

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	something. I cannot tell you why things didn't happen like they should have, except I do know that we have had a lot of agency staff and that could be a contributing factor. As for why the Nurse Practitioner wrote an order for the wanderguard at the end of August, I would suggest you speak with her. My guess is that one of the staff talked to her about hugging or hanging around the doors more." The ED shared she was unaware of any specific policy or procedure related to the use of a wanderguard. In an interview on 10-31-23 at 11:35 a.m., with the facility Nurse Practitioner (NP), she indicated she could not recall which staff member spoke to her regarding Resident B, "but it had to do with him hanging around the doors more than he had been and were concerned with possible exit seeking behaviors. That's why I wrote the order for the wanderguard." A telephone order form dated 8-28-23, and signed by NP 1, indicated, "apply wanderguard." In another interview on 10-31-23 at 2:35 p.m., with the ED, she indicated, an order for a wanderguard placement "is pretty easy and the nurses should be familiar with the process. If you receive an order for a wanderguard, then you should make the appropriate notifications, apply the wanderguard, put the orders into the computer and it should put in the appropriate triggers for checking the placement of the wanderguard and the orders in the computer system will trigger for the wanderguard to be tracked by IDT [interdisciplinary team]. It's all very routine." In an interview on 10-31-23 at 3:20 p.m., with the Corporate Staff, she indicated she had been at the facility last week, conducting a mock survey for the facility. She shared she had identified		QAPI Committee may elect to discontinue the audit.	

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	concerns with Resident B's wanderguard orders, as well as lack of care plans and lack of documentation on the MAR's and TAR's for the use of the wanderguard. She added she was called away to another facility and was unable to finish up some of the correction for that until 10-30-23. A careplan, with an initiation date of 10-30-23, indicated Resident B was at risk for elopement from the facility, related to his elopement risk assessment, as well as "confusion, disorientation, and other cognitive deficits affecting decision making and general awareness." Interventions included for this concern, included, but were not limited to the placement of a wanderguard, with staff to check the placement and function of the wanderguard each shift and to conduct wandering and elopement risk assessments upon admission, quarterly and with any significant change in circumstances. The care plan did not address the elopement which occurred on 9-29-23. 2. The clinical record of Resident E was reviewed on 10-31-23 at 1:05 p.m. Her diagnoses included, but were not limited to, transient ischemic accidents (TIA's), type 2 diabetes with polyneuropathy, peripheral vascular disease, atherosclerotic heart disease, cardiovascular disease, anxiety and high blood pressure. A review of Resident E's most recent Minimum Data Set (MDS) assessment, dated 8-9-23, indicated she was moderately cognitively impaired and had verbal behaviors towards others. It did not indicate any wandering behaviors during the look-back period of the assessment. A review of Resident E's assessments for wandering reflected she was a high wandering risk of 11 on 5-29-23, but had been lowered to a			

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	moderate risk of 10 on 10-26-23. She was assessed as a low elopement risk on 4-24-23, but identified as a high elopement risk of 14 on 7-24-23 and 10-26-23. A progress note, dated 6-30-23 at 5:51 p.m., indicated Resident E "was found wandering in the facility service hall by herself. Staff member found her as they were leaving the building and redirected her back to unit. Administrator notified. Doctor notified by faxing progress note. Wander guard is on right wrist at this time." An associated physician order, dated 7-3-23, indicated, "Wandering- Resident has times where she wanders halls. Chart in a progress note if noted and interventions for redirection," with documentation to be completed each shift for any wandering events. An actual physician order was not recorded until 10-31-23 for the placement and the routine verification of the wanderguard. Resident E was identified by the facility as one of three current residents with a wanderguard alarm. During an observation of Resident E on 10-31-23 at 3:45 p.m., with LPN 4, she indicated she could not locate the wanderguard. LPN 4 indicated the facility routinely places wanderguard bands on a resident's left ankle. Another staff member suggested to look for the band on her right wrist, above her watch and the wanderguard band was located. Resident E was not aware she had a wanderguard band on. In an interview on 10-31-23 at 3:20 p.m., with the Corporate Staff, she indicated she had been at the facility last week, conducting a mock survey for the facility. She shared she had identified concerns with another resident's wanderguard orders, as well as lack of care plans and lack of documentation on the MAR's and TAR's for the			

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	use of the wanderguard. She added she was called away to another facility and was unable to finish up some of the correction for that until 10-30-23. She added when Resident E's clinical record was reviewed today, "[it] was missing some of the same things." A review of Resident E's care plans revealed a care plan for "at risk for elopement" was initiated on 8-4-23. Initial interventions listed were to involve the resident in activities and to conduct wander risk assessments quarterly and as needed. An updated intervention, dated 10-30-23, included, "wanderguard." On 10-31-23 at 11:15 a.m., the ED provided a copy of a policy entitled, "Baseline Care Plan Assessment/Comprehensive Care Plans." This policy had was identified as last updated on 9-18-18, and was identified as the current policy utilized by the facility. It indicated, "It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of Admission. The Baseline Care Plan is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission...The Baseline Care Plan will continue to be updated with changes in risk factors, goals and interventions until the Comprehensive Care Plan is completed. The Baseline Care Plan will be discontinued upon the completion of the Comprehensive Care Plan. The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions...The Baseline Care Plan will continue to be revised until the final completion of the Comprehensive Care Plan...The Comprehensive Care Plan will be finalized within 7			

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	days of the completion of the Full Comprehensive MDS assessments and corresponding CAA's...The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues. The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning/CQI meetings where in-depth review of the 24-hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary." This Federal tag relates to Complaint IN00419550. 3.1-35(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision, related to the use of a wanderguard (safety device used as an audible alarm to notify staff of an exit or elopement attempt from a secured area), for 2 of 3 residents reviewed for the	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** It is the policy of this facility to be free of accidents/hazards related to supervision/devices. **What corrective action will be**	11/27/2023

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	use of wanderguards. (Resident B and E) Findings include: 1. The clinical record of Resident B was reviewed on 10-30-23 at at 2:55 p.m. His diagnoses included, but were not limited to a history of traumatic brain injury (TBI), unspecified encephalopathy, viral hepatitis, falls and mild neurocognitive disorder. His most recent Minimum Data Set (MDS) assessment, dated 8-29-23, indicated he has moderate cognitive impairment, is ambulatory without use of an assistive device and did not indicate any wandering behaviors during the look-back period of the assessment. A review of Resident B's assessments for wandering and elopement reflected his admission assessment on 7-3-23 for wandering was a moderate risk, but he was not an elopement risk. Wandering risk assessments on 7-6-23 and 8-5-23 were unchanged. However, the next listed elopement risk assessment conducted on 10-26-23 identified him as a high risk. Multiple observations of Resident B confirmed he had a wanderguard placed onto his left ankle during the survey time. Resident B was identified by the facility as one of three current residents with a wanderguard alarm. In an interview with the Executive Director (ED) on 10-30-23 at 3:58 p.m., she indicated Resident B had a wanderguard since she began employment on 8-28-23. "We just noticed that he did not have an official order on file for it until today when we were reviewing it. This is the only elopement we have had since I have been here." The ED indicated Resident B was near the facility's		**accomplished for residents affected?** For residents identified in this survey, their most recent elopement risk assessment has been reviewed and found to be appropriate. Their care plan has been updated with appropriate elopement risk. Orders for wander guard device, as well as orders to check function and placement every shift, have been verified in the electronic medical record as an active order and the resident was observed wearing the device. Completed by 10/31/23. **How will other residents with potential to be affected be identified?** All residents have the potential to be affected. An audit of the residents with a wander guard to verity placement and function was completed on 10/31/23. Any resident identified as an elopement risk has had a care plan revision to include elopement risk and has an order for a wander guard and an order to check function and placement every shift. Completed by 11/27/23. **Measures to be put in place to ensure practice does not recur:** All nursing staff will be re-educated by the Director of Nursing/designee on the following policies: 1 Elopement and Missing	

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	entrance on 9-29-23, when a pizza delivery person brought in a delivery. "He held the door open for him [Resident B] and the alarm was going off and the guy didn't even seem to notice it was going off. As soon as the resident got outside, he took off like the wind. No walker, no rollator, just flew! It took us about 2 minutes to catch up to him and get him turned around and brought back in the building. He was not out of sight at any point. When the delivery guy got back to the entry, he made a comment to the effect of, 'Oh, I guess I let that guy out.'" In a second interview with the ED on 10-31-23 at 11:25 a.m., she recalled Resident B received his wanderguard on the first or second day of her employment at the facility, when the facility's Nurse Practitioner (NP) wrote an order for it. "I just assumed that the nursing staff had inputted the order into the system, which of course, would have triggered the care plan and it getting put on the MAR [medication administration record] or TAR [treatment administration record] for the daily checks. Well, that didn't happen, until afterward. He did receive the wanderguard to wear at that time, but none of the rest of the things got done until recently. As a matter of fact, it was audited just right before you showed up, when my corporate person was here. I was very honest with her, I told her, just like I'm telling you, that I assumed all of those things got done, but you know what can happen when one assumes something. I cannot tell you why things didn't happen like they should have, except I do know that we have had a lot of agency staff and that could be a contributing factor. As for why the Nurse Practitioner wrote an order for the wanderguard at the end of August, I would suggest you speak with her. My guess is that one of the staff talked to her about hugging or		Resident Prevention 2 Baseline and Comprehensive Care planning Nurses will be given additional education by the Director of Nursing/designee on wander guard order entry to include: 1 Order for use of device 2 Order to check placement and function every shift Additionally, any employee who fails to comply with the points of the in-service may be further educated and / or progressively disciplined as indicated. Inservices will be completed by 11/27/23. **How will corrective action be monitored?** The Director of Nursing and/or designee will use the Exit Seeking Compliance Audit to audit each admission, re-admission and significant change in exit seeking behaviors for all residents to ensure an elopement risk assessment has been completed and if identified as an elopement risk, an order for a wander guard/check placement and function has been obtained, and the elopement risk is care planned. Any corrections needed will be made when found during the audit. This audit will occur for every admission, re-admission and any significant change in exit seeking behaviors or all residents for a	

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(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
	hanging around the doors more." The ED shared she was unaware of any specific policy or procedure related to the use of a wanderguard. In an interview on 10-31-23 at 11:35 a.m., with the facility Nurse Practitioner (NP), she indicated she could not recall which staff member spoke to her regarding Resident B, "but it had to do with him hanging around the doors more than he had been and were concerned with possible exit seeking behaviors. That's why I wrote the order for the wanderguard." A telephone order form dated 8-28-23, and signed by NP 1, indicated, "apply wanderguard." In another interview on 10-31-23 at 2:35 p.m., with the ED, she indicated, an order for a wanderguard placement "is pretty easy and the nurses should be familiar with the process. If you receive an order for a wanderguard, then you should make the appropriate notifications, apply the wanderguard, put the orders into the computer and it should put in the appropriate triggers for checking the placement of the wanderguard and the orders in the computer system will trigger for the wanderguard to be tracked by IDT [interdisciplinary team]. It's all very routine." In an interview on 10-31-23 at 3:20 p.m., with the Corporate Staff, she indicated she had been at the facility last week, conducting a mock survey for the facility. She shared she had identified concerns with Resident B's wanderguard orders, as well as lack of care plans and lack of documentation on the MAR's and TAR's for the use of the wanderguard. She added she was called away to another facility and was unable to finish up some of the correction for that until 10-30-23.		period of not less than 6 months. The DON and/or designee will present audit findings to the QAPI Committee at the monthly meeting. The QAPI Committee will review audit findings for a period of not less than 6 months and when compliance is 95% or better, the QAPI Committee may elect to discontinue the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	10/31/2023

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	A careplan, with an initiation date of 10-30-23, indicated Resident B was at risk for elopement from the facility, related to his elopement risk assessment, as well as "confusion, disorientation, and other cognitive deficits affecting decision making and general awareness." Interventions included for this concern, included, but were not limited to the placement of a wanderguard, with staff to check the placement and function of the wanderguard each shift and to conduct wandering and elopement risk assessments upon admission, quarterly and with any significant change in circumstances. The care plan did not address the elopement which occurred on 9-29-23. 2. The clinical record of Resident E was reviewed on 10-31-23 at 1:05 p.m. Her diagnoses included, but were not limited to, transient ischemic accidents (TIA's), type 2 diabetes with polyneuropathy, peripheral vascular disease, atherosclerotic heart disease, cardiovascular disease, anxiety and high blood pressure. A review of Resident E's most recent Minimum Data Set (MDS) assessment, dated 8-9-23, indicated she was moderately cognitively impaired and had verbal behaviors towards others. It did not indicate any wandering behaviors during the look-back period of the assessment. A review of Resident E's assessments for wandering reflected she was a high wandering risk of 11 on 5-29-23, but had been lowered to a moderate risk of 10 on 10-26-23. She was assessed as a low elopement risk on 4-24-23, but identified as a high elopement risk of 14 on 7-24-23 and 10-26-23. A progress note, dated 6-30-23 at 5:51 p.m., indicated Resident E "was found wandering in the facility service hall by herself. Staff member found			

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	her as they were leaving the building and redirected her back to unit. Administrator notified. Doctor notified by faxing progress note. Wander guard is on right wrist at this time." An associated physician order, dated 7-3-23, indicated, "Wandering- Resident has times where she wanders halls. Chart in a progress note if noted and interventions for redirection," with documentation to be completed each shift for any wandering events. An actual physician order was not recorded until 10-31-23 for the placement and the routine verification of the wanderguard. Resident E was identified by the facility as one of three current residents with a wanderguard alarm. During an observation of Resident E on 10-31-23 at 3:45 p.m., with LPN 4, she indicated she could not locate the wanderguard. LPN 4 indicated the facility routinely places wanderguard bands on a resident's left ankle. Another staff member suggested to look for the band on her right wrist, above her watch and the wanderguard band was located. Resident E was not aware she had a wanderguard band on. In an interview on 10-31-23 at 3:20 p.m., with the Corporate Staff, she indicated she had been at the facility last week, conducting a mock survey for the facility. She shared she had identified concerns with another resident's wanderguard orders, as well as lack of care plans and lack of documentation on the MAR's and TAR's for the use of the wanderguard. She added she was called away to another facility and was unable to finish up some of the correction for that until 10-30-23. She added when Resident E's clinical record was reviewed today, "[it] was missing some of the same things." A review of Resident E's care plans revealed a			

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	care plan for "at risk for elopement" was initiated on 8-4-23. Initial interventions listed were to involve the resident in activities and to conduct wander risk assessments quarterly and as needed. An updated intervention, dated 10-30-23, included, "wanderguard." On 10-31-23 at 11:15 a.m., the ED provided a copy of a policy entitled, "Elopement and Missing Resident Prevention," with an effective date of 4-20-23. This policy indicated, "It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk of elopement. Prevention of Missing Residents and Elopements: Environmental: All personal safety devices, (i.e., WanderGuard bracelets, door alarms), will have function validated at least daily...All residents shall be assessed for the risk of elopement utilizing an elopement risk assessment upon admission, quarterly, annually and upon significant change of condition to include an attempt to elope or an actual elopement...Residents at risk for elopement will be indicated on the resident's plan of care. The plan of care will be reviewed and updated at least quarterly and updated as necessary. On 10-31-23 at 11:15 a.m., the ED provided a copy of a policy entitled, "Baseline Care Plan Assessment/Comprehensive Care Plans." This policy had was identified as last updated on 9-18-18, and was identified as the current policy utilized by the facility. It indicated, "It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of Admission. The Baseline Care Plan is intended to promote			

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	continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission...The Baseline Care Plan will continue to be updated with changes in risk factors, goals and interventions until the Comprehensive Care Plan is completed. The Baseline Care Plan will be discontinued upon the completion of the Comprehensive Care Plan. The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions...The Baseline Care Plan will continue to be revised until the final completion of the Comprehensive Care Plan...The Comprehensive Care Plan will be finalized within 7 days of the completion of the Full Comprehensive MDS assessments and corresponding CAA's...The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues. The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning/CQI meetings where in-depth review of the 24-hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary." This Federal tag relates to Complaint IN00419550. 3.1-45(a)(2)			