**NAME OF PROVIDER OR SUPPLIER**

ROSEWALK VILLAGE AT LAFAYETTE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1903 UNION ST
LAFAYETTE, IN 47904

**NAME OF PROVIDER OR SUPPLIER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

**PREFIX**

**TAG**

**LEVEL**

**DESCRIPTION**

**F 0000**

Bldg. 00

This visit was for a Recertification and State Licensure Survey.

Survey dates: June 6, 7, 8, 9, 12 and 13, 2017

Facility number: 000051

Provider number: 155121

AIM number: 100275490

Census bed type:

SNF/NF: 111

SNF: 13

Total: 124

Census payor type:

Medicare: 23

Medicaid: 96

Other: 5

Total: 124

These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.

Quality Review was completed on June 20, 2017.

**F 0157**

SS=D

Bldg. 00

483.10(g)(14)

NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident’s physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

_____________________________________________________________________________________________________
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F0157</td>
<td>06/13/2017</td>
<td>12:00:00AM</td>
<td>results in injury and has the potential for requiring physician intervention;</td>
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<td>(B) A significant change in the resident’s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</td>
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<td>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</td>
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<td>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</td>
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<td>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</td>
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<td>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</td>
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<td>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</td>
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<td>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</td>
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<td>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</td>
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<td>Based on interview and record review,</td>
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<td>F157-Notify of Changes</td>
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<td>07/13/2017</td>
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the facility failed to notify the medical doctor (MD) after a resident with a diagnosis of congestive heart failure gained more than 3 pounds in one day, after a daily weight was not obtained for a resident receiving dialysis and after a resident had a significant weight loss for 3 of 3 residents reviewed for Physician notification (Residents 31, 139 and 74).

Findings include:

1. Resident 31's record was reviewed on 06/8/2017 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, acute and chronic respiratory failure, type 2 Diabetes Mellitus, and heart failure.

A Quarterly Minimum Data Set Assessment dated 2/1/2017, Section I. Active Diagnoses indicated Resident 31 had an active diagnosis of heart failure.

A care plan for a therapeutic diet related to diabetes, congestive heart failure and body weight was initiated on 8/12/2016. The goal was the "resident will have no significant weight changes."

Interventions included, but were not limited to, monitor weight and to notify the MD/Family of significant weight changes.
A physician's order dated 8/3/2016, indicated to weigh the resident every day related to CHF (congestive heart failure) and to notify the MD of a weight gain of 3 pounds in a day or 5 pounds in a week.

Review of Resident 31's "Documentation Administration History" for the order "Daily Weight for CHF" indicated from 4/12/2017 to 5/12/2017 the resident had not been weighed on 11 separate days; April 12, 13, 14, 15, and 21, as well as, May 1, 3, 5, 6, 7, and 11. Documentation from 5/13/2017 through 6/11/2017 indicated 3 days with no weight documentation.

On 4/19/2017 the resident weighed 348 pounds (a 7 pound weight gain). Documentation indicated the MD was not notified.

On 4/26/2017 the resident weighed 343.5 pounds. On 4/27/2017 the resident weighed 347 pounds (a 3.5 pound weight gain). Documentation indicated the MD was not notified.

On 5/17/2017 the resident weighed 343 pounds. On 5/18/2017 the resident weighed 354 pounds (an 11 pound weight gain). Documentation indicated the MD was not notified.

To ensure that the deficient practice does not recur:

Executive Director and/or designee will in-service the nursing staff on or before 7/6/17 on the facility policy related to change of condition and resident, medical doctor (MD), and resident representative notification. DNS/designee will review all residents with orders for daily weights to ensure weights are obtained and notification is completed timely and interventions are put into place if needed.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Change in Condition daily for 4 weeks and weekly for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
During an interview on 6/13/2017 at 10:07 a.m., UM 2 indicated the MD should have been notified, but was not notified. Resident 139's record was reviewed on 6/8/17 at 12:14 p.m.

Diagnoses included, but were not limited to, chronic kidney disease, acute kidney failure and fluid overload.

A care plan dated 5/11/7, indicated the resident was receiving hemodialysis and was at a risk for fluid imbalance and the approaches included, but were not limited to, daily weights and to observe for symptoms of fluid volume excess such as weight gain.

A physician order dated 5/19/17, indicated daily weight due to dialysis.

The electronic documentation administration record showed no weight was completed for 5/23/17 and included the comment "machine unstable".

During an interview on 6/9/17 at 2:32 p.m., the Unit Manager 1 indicated the resident was weighed using a hoyer lift and the staff should have obtained a different hoyer lift to complete the resident's daily weight if the machine was unstable. She also indicated the physician should have been notified if an order was not followed.

Compliance Date: 7/13/17
3. Resident 74's closed record was reviewed on 6/9/17 at 11:10 a.m. Diagnoses included, but were not limited to, colostomy, hypertension and malignant neoplasm of endometrium.

A care plan dated 3/28/17, indicated the resident required a therapeutic diet related to hypertension and the resident's usual body weight was 175 to 185 pounds. The care plan goal was to maintain the resident's weight within the usual body weight and the approaches included, but were not limited to, monitor weight and notify physician of significant weight changes.

The weight log indicated the following weights for Resident 74:

- a. On 3/17/17 the resident weighed 178.8 pounds.
- b. On 3/28/17 the resident weighed 178 pounds.
- c. On 4/06/17 the resident weighed 166 pounds.
- d. On 4/17/17 the resident weighed 164 pounds.

During an interview on 6/13/17 at 10:47 a.m., the Nurse Consultant indicated the physician was not notified of the significant weight loss on 4/06/17 and no interventions were in place until 4/19/17.
when the weight loss was reviewed by the dietician.

A current policy titled "Resident Change of Condition" revised 1/2015, received from the Executive Director on 6/13/2017 at 10:00 a.m., indicated "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...."

3.1-5(a)(2)

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<tr>
<td>F 0166</td>
<td>SS=E</td>
<td>Bldg. 00</td>
<td>483.10(j)(2)-(4)</td>
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RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through
postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of
Based on interview and record review, the facility failed to follow-up on resident grievances in a timely manner for 4 of 19 grievances reviewed (Residents 12, 21, 31, and 83).

Findings include:

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents’ rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents’ rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

Based on interview and record review, the facility failed to follow-up on resident grievances in a timely manner for 4 of 19 grievances reviewed (Residents 12, 21, 31, and 83).

Findings include:

F 0166 F166- Right to Prompt Efforts to Resolve Grievances

It is the practice of this facility that resident or family concerns/grievances occurring during the resident’s stay in the facility shall, whenever possible, be responded to by the designated Grievance Official in a timely and effective manner.
Resident grievances were reviewed on 6/9/2017 at 2:00 p.m.

1. Staff received a Concern/Grievance Form for Resident 21 on 1/20/2017. Section II of the form indicated UM 2 spoke with the resident on 1/28/2017, eight days after the grievance was filed.

2. Staff received a Concern/Grievance Form for Resident 12 filed by a family member on 2/7/2017. Section II of the form indicated staff spoke with the resident's family member on 2/27/2017, 20 days after the grievance was filed.

3. Staff received a Concern/Grievance Form for Resident 83 on 5/23/2017. Section II of the form indicated UM 1 spoke with the resident on 5/29/2017, 6 days after the grievance was filed. Section III of the form indicated the schedule pertaining to the grievance was not changed until 6/8/2017, 16 days after the grievance was filed.

4. Staff received a Concern/Grievance Form for Resident 31 on 5/24/2017, regarding his showers not being completed as scheduled. Section II of the form indicated UM 2 spoke with the resident about the grievance on 5/30/2017, 6 days after the grievance was filed. Section III of the form indicated

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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</td>
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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
- Resident 12 grievance was resolved
- Resident 21 grievance was resolved
- Resident 31 grievance was resolved
- Resident 83 grievance was resolved

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
- Any resident filing a grievance has the potential to be affected by this finding. An audit will be completed by the ED/designee of all grievances ensure they have been resolved.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
- The ED/designee will in-service the Customer Care Representatives on the grievance policy and the timeliness of completely grievances on or before 7/6/17. All outstanding grievances will be reviewed daily in morning meeting.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:
the grievance was brought up during a care plan meeting on 6/8/2017. Review of the "Point of Care History" for Resident 31 indicated he received a shower on 5/30/2017, the day UM 2 spoke with the resident, and as of 6/8/2017, Resident 31 had 0 showers in the month of June.

During an interview on 6/12/2017 at 3:24 p.m., the Administrator indicated staff had "72 hours for actions to be taken" regarding resident grievances.

Review of a current policy revised on 11/2016, received from the Administrator on 6/12/2017 at 3:13 p.m. indicated "....Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance Form was received. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and to ensure their satisfaction. Actions taken must be documented...Responses, appropriate plan/resolution to all complaints, and follow up with resident and/or family will be made within 72 hours...."

The grievance was brought up during a care plan meeting on 6/8/2017. Review of the "Point of Care History" for Resident 31 indicated he received a shower on 5/30/2017, the day UM 2 spoke with the resident, and as of 6/8/2017, Resident 31 had 0 showers in the month of June.

During an interview on 6/12/2017 at 3:24 p.m., the Administrator indicated staff had "72 hours for actions to be taken" regarding resident grievances.

Review of a current policy revised on 11/2016, received from the Administrator on 6/12/2017 at 3:13 p.m. indicated "....Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance Form was received. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and to ensure their satisfaction. Actions taken must be documented...Responses, appropriate plan/resolution to all complaints, and follow up with resident and/or family will be made within 72 hours...."

By what date the systemic changes will be completed:
Compliance Date: 7/13/17
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**Identification Number:** MULTIPLE CONSTRUCTION 155121

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Street Address, City, State, Zip Code:** 1903 UNION ST LAFAYETTE, IN 47904

**Date Survey Completed:** 06/13/2017

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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 0241</td>
<td>3.1-7(a)(2) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
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<td><strong>F241-Dignity and Respect of Individuality</strong></td>
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<tr>
<td>SS=D Bldg. 00</td>
<td>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</td>
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<td><strong>07/13/2017</strong></td>
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<td>Based on observation, interview and record review, the facility failed to ensure a resident's body was fully covered during transport in the common areas for 1 of 4 residents reviewed for dignity (Resident 104).</td>
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<td><strong>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</strong></td>
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<td>Finding includes:</td>
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<td>Resident 104 back was immediately covered. Resident 104 was aided with obtaining new clothes that fit her. C.N.A. was provided education on dignity and respect of a resident.</td>
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<td>On 06/07/2017 at 3:55 p.m., Resident 104 was observed to be seated in a wheelchair, at the reception desk located at the entrance to the facility and she was dressed in a hospital gown. The hospital gown was not closed in the rear and Resident 104's back was fully exposed. Both of her sides were partially showing and her brief was exposed on both sides. An unidentified CNA was standing</td>
<td></td>
<td><strong>Residents 104 back was immediately covered. Resident 104 was aided with obtaining new clothes that fit her. C.N.A. was provided education on dignity and respect of a resident.</strong></td>
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behind Resident 104's wheelchair and had wheeled the resident to the reception desk from the resident's upstairs room.

During an interview on 06/07/2017 at 3:59 p.m., the Administrator indicated the CNA should have put a sheet/blanket or a rear facing gown on the resident to ensure she was fully covered. At that time, a blanket was put around Resident 104's back to cover her exposed body.

Resident 104's record was reviewed on 06/09/2017 at 3:01 p.m. Diagnoses included, but were not limited to, anemia, restless leg syndrome, lymphedema, cellulitis of an unspecified part of the limb, heart failure, Type 2 Diabetes, anxiety disorder, depressive episodes and morbid obesity.

An Annual Minimum Data Set (MDS) Assessment dated 04/27/2017, indicated Resident 104 required extensive assistance from one staff member for locomotion on and off the unit.

During an interview on 06/09/2017 at 12:32 p.m., Resident 104 indicated she did not have any clothes which fit her right now and spends a lot of time in her room. She indicated on Wednesday when she went downstairs to the reception desk, she was ordering new night shirts.
since her old ones no longer fit. She indicated the CNA came to her room and requested to weigh the resident. At that time, Resident 104 requested to visit the reception desk. Resident 104 indicated when they left the room she thought they were going down the hall to the second floor weight machine and instead the CNA wheeled her to the elevator and downstairs to the first floor weight machine to weigh her and then to the reception desk. Resident 104 indicated a CNA had wheeled her out of her room without fully covering her before. She indicated "it does not happen often but it had happened a couple of times."

During an interview on 06/09/2017 at 3:17 p.m., the Director of Nursing indicated the CNA should have draped the resident before bringing her downstairs.

A facility document titled "Certified Nursing Assistant (CNA) Position Description" dated 10/2014, received from the Director of Nursing on 06/09/2017 at 3:19 p.m., indicated "...Provides care in a manner that protects and promotes resident rights, dignity, privacy, confidentiality, self-determination and active participation. Offers and respects resident choices in matters of daily routine..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**

155121

**DATE SURVEY COMPLETED:**

06/13/2017

**NAME OF PROVIDER OR SUPPLIER:**

ROSEWALK VILLAGE AT LAFAYETTE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1903 UNION ST

LAFAYETTE, IN 47904

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<tr>
<td>F0242</td>
<td>SS=D</td>
<td>Bldg. 00</td>
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<td>483.10(f)(1)-(3)</td>
<td>SELF-DETERMINATION - RIGHT TO MAKE CHOICES</td>
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<td>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</td>
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<td>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</td>
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<td>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</td>
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<td>Based on interview and record review, the facility failed to ensure residents had the right to choose when they would like to take a shower for 1 of 5 resident reviewed for choices (Resident 31).</td>
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<td>During an interview on 6/08/2017 at 8:52 a.m., Resident 31 indicated he preferred to have showers at night before going to bed.</td>
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<td>Resident 31's record was reviewed on 06/8/2017 at 2:19 p.m. Diagnoses</td>
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**F0242-Self Determination-Right to Make Choices**

It is the practice of this facility to ensure residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident.

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Resident 31 shower preference was changed

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:**
included, but were not limited to, cerebral infarction, muscle weakness, acute and chronic respiratory failure, type 2 Diabetes Mellitus, and heart failure.

A Quarterly Minimum Data Set dated 2/1/2017, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15. Section G-Functional Status, ADL Assistance, J. Personal Hygiene was marked as extensive assistance. Total dependence was marked for Bathing, Self Performance.

Review of a care plan dated 8/3/2016, indicated the "...resident requires assistance with ADLs...." Interventions included, but were not limited to, "...provide shower two times per week, partial bath in between, Prefers PM shower....."

Review of a "Concern/Grievance Form" for Resident 31 dated 5/24/2017, indicated the resident "is not getting his 2 baths every week. And he said he would like to have a bath every day." The response of the grievance dated 5/30/2017 indicated the UM 2 spoke with the resident and that he prefers evening showers.

During an interview on 6/08/2017 at 3:07 p.m., LPN 2 indicated Resident 31 was
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING

**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Address:** 1903 UNION ST LAFAYETTE, IN 47904

**Summary Statement of Deficiencies** (Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
</table>
| F 0250 | SS=E | Bldg. 00 | **Changes will be completed:**  
Compliance Date: 7/13/17 |

- **F 0250**

**483.40(d) Provision of Medically Related Social Service**

(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

Based on observation, interview and record review, the facility failed to schedule to receive his showers on Tuesday and Saturday during the day shift.

The unit "Shower Book" indicated Resident 31 was scheduled to receive his showers during the day shift on Tuesdays and Saturdays.

A current facility document titled "Resident Rights" no date, received from the Director of Nursing on 6/9/2017 at 3:19 p.m., indicated "...(b) Self-determination and participation. The resident has the right to- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care...(3) Make choices about aspects of his or her life in the facility that is significant to the resident...."

3.1-3(u)(1)
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>00</td>
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<td>It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Smoking assessments have been completed for Resident 70, 77, 32, and 75. Oral assessment including any concerns with pain has been completed with MD notification of assessment by a Licensed Nurse for Resident 77. An offsite Dental referral has been made for Resident 77 and a dental care plan has been put into place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that utilize electronic cigarettes and require dental services have the potential to be affected by this finding. Audit of all residents currently utilizing electronic cigarettes has been completed and smoking assessments are up to date. Audit of all residents on the dental list has been reviewed and referrals made if needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</td>
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During an interview on 06/09/2017 at 10:11 a.m., the Social Service Director (SSD) indicated smoking risk assessments should be completed on admission, quarterly or with a significant change and Resident 70 had not had an assessment completed on admission or quarterly after admission.

2. Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyaglia and insomnia.

A Physician's Order dated 08/31/2016, indicated the resident may use an electronic cigarette.

Resident 77's care plan addressed the problem the resident wishes to use an electronic cigarette. Interventions included, but were not limited to, "...05/06/2013- Assess for safety awareness r/t [related to] smoking an electronic cigarette...."

No smoking assessments for Resident 77 were located.

During an interview on 06/12/2017 at

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The SSD/designee will be responsible for completing the QAPI Audit tool Smoking Policy weekly for 4 weeks then monthly for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
Compliance Date: 7/13/17
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

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<tr>
<th>X1) Provider/Supplier/CLIA Identification Number:</th>
<th>155121</th>
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<tr>
<td>X2) Multiple Construction:</td>
<td>A. Building</td>
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<td>B. Wing</td>
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<td>X3) Date Survey Completed:</td>
<td>06/13/2017</td>
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**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Street Address, City, State, Zip Code:**
1903 UNION ST
LAFAYETTE, IN 47904

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<tr>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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- **DATE SURVEY COMPLETED:**
  - 06/13/2017

**4:11 p.m., the SSD indicated Resident 77 had not had a smoking risk assessment completed since 12/2014.**

3. Resident 32's record was reviewed on 06/12/2017 at 2:00 p.m. Diagnoses included, but were not limited to, malignant neoplasm of an unspecified part of the bronchus or lung, alcohol dependence, personal history of nicotine dependence, asthma, dementia with behavioral disturbance, heart failure, depressive episodes and anxiety disorder.

A Physician's Order dated 12/31/2015, indicated the resident may have an electronic cigarette due to nicotine anxiety.

Resident 32's care plan addressed the problem the resident used an electronic cigarette. Interventions included, but were not limited to, "...12/31/2015- IDT to assess resident's ability to use the electronic cigarette upon admission/quarterly or upon a significant change...."

No smoking assessments for Resident 32 were located.

During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 32 had a smoking risk assessment completed...
4. Resident 75's record was reviewed on 06/12/2017 at 2:50 p.m. Diagnoses included, but were not limited to, cough, insomnia, depressive episodes, anxiety, obstructive sleep apnea and chronic obstructive pulmonary disease.

A Physician's Order dated 11/20/2014, indicated the resident may have an electronic cigarette at bedside.

Resident 75's care plan addressed the problem the resident chose to use an electronic cigarette while at the facility. Interventions included, but were not limited to, "...04/15/2013- Do smoking risk assessment...."

No smoking assessments for Resident 75 were located.

During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 75 had a smoking risk assessment completed on 05/16/2017 and the last previous assessment was completed 12/17/2014.

During an interview on 06/13/2017 at 8:54 a.m., the Administrator indicated Social Services would be the department to complete the smoking risk assessments.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
IDENTIFICATION NUMBER: 155121
A. BUILDING
B. WING

NAME OF PROVIDER OR SUPPLIER
ROSEWALK VILLAGE AT LAFAYETTE
1903 UNION ST
LAFAYETTE, IN 47904

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

initially, quarterly and with a significant change according to the facility policy.

A current facility policy titled "Electronic Cigarettes" dated 04/2016, received from the Administrator on 06/09/2017 at 12:25 p.m., indicated "...Allowable electronic cigarettes include those that are self contained or use cartridges; those that use liquid nicotine are not permitted...Each resident requesting to use an electronic cigarette must be screened at admission and/or quarterly, or any significant change, by the IDT team...."

5. On 06/06/2017 at 02:05 p.m., Resident 77 was observed to have her own teeth with missing and broken teeth on the top left side of her mouth.

Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

An Annual Minimum Data Set (MDS) Assessment dated 08/31/2016, was marked as "no natural teeth or tooth fragments" in the Section L- Oral/Dental Status. The Section V- Care Area

FORM CMS-2567(02-99) Previous Versions Obsolete
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 155121

**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** Rosewalk Village at Lafayette

**Street Address, City, State, Zip Code:**
- 1903 Union St
- Lafayette, IN 47904

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<th>Provider's Plan of Correction</th>
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#### Summary Statement of Deficiencies

Assessment (CAA) Summary, indicated "...Resident triggered for CAA due to she has no dentures or natural teeth, resident has no difficulty with chewing or swallowing. Resident denies oral pain. Resident states she has no oral sores, refused oral exam. Resident is able to enjoy foods per her choice and says she will not have dentures and does not need teeth to enjoy food. Resident does own oral care per her choice...Will proceed with a care plan...."

No care plan for dental was located.

A Progress note dated 01/17/2017 at 5:50 a.m., indicated Resident 77 had a complaint of left lower mouth pain and stated it felt like it was infected. The left jaw, left side of the face, and left chin area were extremely reddened and swollen. The Medical Doctor (MD) was notified and stated to "refer to a dentist." The resident was informed and stated she did not wish to go out of the facility to see a dentist.

A dental note from the facility's ancillary on site dentistry service dated 01/12/2017, indicated Resident 77 was seen in her room due to the facility reported recent dental discomfort. Patient reported discomfort of the lower left quadrant which was alleviated with...
Tylenol. An Intra-oral exam revealed many retained, unrestorable root tips in the maxilla, poor oral hygiene and heavy plaque and calculus throughout mandibular remaining teeth. "... Pt [Patient] pointed to tooth #19: gross debridement recommended prior to fully diagnose caries and existing conditions. Due to quantity of retained roots, pt dental anxiety and underlying general health, recommend referral to offsite dental clinic for full mouth radiographs and likely extraction per pt's request. Pt is very apprehensive to pursue dental care as she has not been to a dentist for many years...."

No follow up progress notes, dental notes, or referral to an offsite dental clinic were located.

During an interview on 06/12/2017 at 10:49 a.m., Resident 77 indicated she had her own teeth with some missing and a few broken teeth which broke off while she was eating her food at the facility and she had told the dentist "she wanted her teeth removed, well at least the broken ones removed." She indicated "having missing front teeth depresses her and embarrasses her because she likes to smile and would love to have teeth to smile again." She indicated she was "a little scared of the dentist but who
During an interview on 06/12/2017 at 4:05 p.m., the Nursing Consultant indicated the facility should have followed up on Resident 77's wishes to pursue offsite dental care after the dentist seen her at the facility, re-evaluated her pain, set up the appointment and documented in the progress notes.

During an interview on 06/13/2017 at 9:31 a.m., the Social Service Director indicated when the facility dentist sees a resident and would make a note indicating the need for outside services, the Social Services department would address it first by reviewing the note and then would verbally tell the nursing staff so an appointment could have been made.

A current facility policy titled "Dental Services" dated revised 01/2016, received from the Social Service Director on 06/13/2017 at 9:36 a.m., indicated "...The facility will obtain contracted outside dental services to meet the routine and emergency dental needs of each resident...For residents who chose to refuse services, dental service options may be reviewed with the residents as needed...The facility will assist in scheduling and transporting residents to
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X(5)) COMPLETION DATE</th>
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<tr>
<td>F 0258</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>dental appointments as needed. The facility will make referrals to dental services as needed for dental issues or missing dentures....&quot;</td>
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<td>3.1-34(a)(2)</td>
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<td>483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels.</td>
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<td>Based on observation and interview, the facility failed to provide comfortable sound levels in 1 of 3 dining areas (The Main Dining Room). Finding includes:</td>
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<td>During an observation on 6/6/17 at 11:55 a.m., the main dining room had loud music playing during the entire meal time.</td>
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<td>During an interview on 6/7/17 at 10:58 a.m., Resident 82 indicated she did not eat dinner down in the main dining room often because the music was too loud.</td>
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<td>During an observation on 6/8/17 at 12:27 p.m., music was being played loudly in</td>
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**F 0258**

**F258-Maintenance of Comfortable Sound Levels**

It is the practice of this facility to maintain comfortable sound levels in the facility for the residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Radio was turned down in the dining room. ED/designee has followed up with resident 82 and 31 to ensure there are no further concerns with volume of the radio in the dining room.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

ED/designee will conduct daily
the main dining room with residents present and the staff were talking loudly to be heard over the music.

During an interview on 6/08/17 at 8:59 a.m., Resident 31 indicated the main dining room was too loud because people were trying to talk over the sound of the radio and one resident controlled the volume on the radio.

During an interview on 10:16 a.m., the Administrator indicated the residents are not to adjust the sound level on the radio in the main dining room and only the staff were to set the volume of the radio due to the outcome of a grievance about noise in the dining room.

During an interview on 6/12/17 at 12:03 p.m., the Administrator indicated he was incorrect and no grievance had been completed about the sound in the dining room. He indicated the sound was reviewed during resident council.

3.1-19(f)
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:
155121

### MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

### DATE SURVEY COMPLETED
06/13/2017

### NAME OF PROVIDER OR SUPPLIER
ROSEWALK VILLAGE AT LAFAYETTE

1903 UNION ST
LAFAYETTE, IN 47904

### SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
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<tbody>
<tr>
<td>F 0275</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS</td>
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<td>(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</td>
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<td>(iii) Not less than once every 12 months. Based on interview and record review, the facility failed to complete Annual Minimum Data Set (MDS) Assessments timely for 2 of 23 residents reviewed for MDS assessments (Resident 104 and 30).</td>
</tr>
</tbody>
</table>

Findings include:

1. Resident 104’s record was reviewed on 06/09/2017 at 3:01 p.m. Diagnoses included, but were not limited to, anemia, restless leg syndrome, lymphedema, cellulitis of an unspecified part of the limb, heart failure, Type 2 Diabetes, anxiety disorder, depressive episodes and morbid obesity.

The most recent MDS Assessment for Resident 104 was an Annual Assessment which was started on 04/27/2017 and

### PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>F 0275</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>07/13/2017</td>
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</table>

F 0275 - Comprehensive Assess at least every 12 months

It is the practice of this facility to conduct an initial and periodic comprehensive assessment as well as no less than quarterly, accurate, standardized reproducible assessment of each resident’s functional capacity to develop a care plan, to provide the appropriate care and services for each resident and to modify the care plan and care/services based on the resident’s status.

Within the specified time frames outlined in the RAI as defined by CMS RAI Version 3.0 Manual. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 104 and 30 have had an annual assessment completed How other residents having the changes will be completed:

Compliance Date: 7/13/17
indicated it was still "in process."

During an interview on 06/12/2017 at 9:30 a.m., the MDS Coordinator indicated the annual assessment should have been completed within 14 days from the start date.

2. Resident 30's record was reviewed on 06/08/2017 at 12:24 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side, muscle weakness, and type II Diabetes Mellitus.

The most recent MDS Assessment for Resident 30 was an Annual Assessment which was started on 5/16/2017 and indicated it was still "in process."

During an interview on 06/8/2017 at 2:51 p.m., the MDS coordinator indicated the annual assessment should have been completed within 14 days from the start date.

3.1-31(d)(2)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 155121

MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

DATE SURVEY COMPLETED 06/13/2017

NAME OF PROVIDER OR SUPPLIER
ROSEWALK VILLAGE AT LAFAYETTE
1903 UNION ST
LAFAYETTE, IN 47904

ID PREFIX TAG
155121 SS=D Bldg. 00

SUMMARY STATEMENT OF DEFICIENCIES

PREFIX TAG ID
F 0276 SS=D Bldg. 00

(483.20(c)
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS
(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

Based on interview and record review, the facility failed to complete Quarterly Minimum Data Set (MDS) Assessments timely for 2 of 23 residents reviewed for MDS assessments (Resident 77 and 31).

Findings include:

1. Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

The most recent MDS Assessment for Resident 104 was a Quarterly Assessment which started on 04/27/2017 and indicated it was still "in process."

Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
July 13, 2017

F276 Quarterly Assessment At Least Every 3 Months
It is the practice of this facility to conduct an initial and periodic comprehensive as well as no less than quarterly, accurate, standardized reproducible assessment of each resident's functional capacity to develop a care plan, to provide the appropriate care and services for each resident and to modify the care plan and care/services based on the resident's status. Within the specified time frames outlined in the RAI as defined by CMS RAI Version 3.0 Manual. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Resident 77 and 31 Quarterly Assessments have been completed.
During an interview on 06/12/2017 at 9:30 a.m., the MDS coordinator indicated the quarterly assessment should have been completed within 14 days from the start date.

2. Resident 31's record was reviewed on 6/8/2017 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, acute and chronic respiratory failure, type 2 Diabetes Mellitus, and heart failure.

The most recent MDS Assessment for Resident 31 was a Quarterly Assessment which was started on 4/19/2017 and indicated it was "still in process."

During an interview on 06/12/2017 at 9:59 a.m., the MDS Coordinator indicated that the 4/19/2017 Quarterly MDS Assessment was still in process and that it should have been submitted within 14 days of the start date.

3.1-31(d)(3)
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:

**MULTIPLE CONSTRUCTION**

### DATE SURVEY COMPLETED

06/13/2017

### NAME OF PROVIDER OR SUPPLIER

ROSEWALK VILLAGE AT LAFAYETTE

### STREET ADDRESS, CITY, STATE, ZIP CODE

1903 UNION ST
LAFAYETTE, IN 47904

### SUMMARY STATEMENT OF DEFICIENCIES

*(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)*

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**F 0278**

 SS=D Bldg. 00

483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification

(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification

(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:

July 13, 2017
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<td>accurate Minimum Data Set (MDS) Assessments are</td>
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<td>Resident 77, 30, and 114 MDS Assessments have</td>
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Assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

Based on observation, interview and record review, the facility failed to ensure accurate Minimum Data Set (MDS) Assessments were accurately completed regarding the dental status for 2 of 3 residents reviewed for dental services (Resident 77 and 30) and failed to ensure a discharge MDS Assessment was completed upon discharge (Resident 114).

Findings include:

1. On 06/06/2017 at 02:05 p.m., Resident 77 was observed to have her own teeth with missing and broken teeth on the top left side of her mouth.

Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

An Annual MDS Assessment dated 08/31/2016, was marked as "no natural
teeth or tooth fragments" in the Section L- Oral/Dental Status. The Section V-
Care Area Assessment (CAA) Summary,
indicated "...Resident triggered for CAA
due to she has no dentures or natural
teeth, resident has no difficulty with
chewing or swallowing. Resident denies
oral pain. Resident states she has no oral
sores, refused oral exam. Resident is able
to enjoy foods per her choice and says
she will not have dentures and does not
need teeth to enjoy food. Resident does
own oral care per her choice...Will
proceed with a care plan...."

During an interview on 06/12/2017 at
2:49 p.m., the MDS assistant indicated
the residents' dental status was coded
incorrectly and it should have been coded
to read the resident had "obvious or likely
cavity or broken natural teeth."

2. On 06/08/2017 at 9:47 a.m., Resident
30 was observed to have broken and
missing teeth through out her mouth.

Resident 30's record was reviewed on
06/08/2017 at 12:24 p.m. Diagnoses
included, but was not limited to,
hemiplegia and hemiparesis following
other cerebrovascular disease affecting
left non-dominant side, muscle weakness,
and type II Diabetes Mellitus.

An Annual MDS Assessment dated
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 155121  
**Date Surveyed:** 06/13/2017

**Name of Provider or Supplier:** Rosewalk Village at Lafayette  
**Street Address, City, State, Zip Code:** 1903 Union St, Lafayette, IN 47904

**Provider’s Plan of Correction**

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<td>06/02/2016, was marked as &quot;none of the above were present&quot; in the Section L- Oral/Dental Status indicating the resident did not have obvious or likely cavity or broken natural teeth.</td>
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A Nutrition Risk Assessment dated 5/18/2017, indicated the resident had natural teeth and that the condition of her teeth were in "good" condition.

A dental note dated 8/16/2016, indicated Resident 31 had 6 missing Maxillary teeth and 7 missing Mandibular teeth, as well as, 6 Maxillary root tips.

A physician's visit note dated 10/26/2016, in the E/N/M/Throat (ears/nose/mouth/throat) section, poor dentition was noted.

No "Head-to-Toe" nursing assessments were located documenting the resident's poor dentition.

During an interview on 6/09/2017 at 9:34 a.m., Resident 30 indicated she had told nursing staff about her dental problems and that she wanted her teeth pulled.

During an interview on 6/09/2017 at 9:44 a.m., UM 2 indicated nurses are to do weekly head-to-toe assessments and that sometimes nurses do not document their
Assessments.

During an interview on 6/08/2017 at 1:28 p.m., the MDS Coordinator indicated the information for the MDS Assessment comes from, but is not limited to, the nursing staff and the ADL charting. Resident 114’s record was reviewed on 6/8/17 at 3:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, stage I pressure ulcer and dementia.

The resident was discharged on 5/11/17.

The MDS discharge assessment dated 5/11/17, indicated the assessment was "in process" and the skin condition section had not been completed.

During an interview on 6/9/17 at 2:29 p.m., the MDS Coordinator indicated the discharge MDS assessment should have been completed within 14 days of Resident 114's discharge and still had not been completed.

3.1-31(c)(8)
3.1-31(c)(9)
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00

**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Street Address, City, State, Zip Code:** 1903 UNION ST LAFAYETTE, IN 47904

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<td>F 0279</td>
<td>SS=D</td>
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<td>483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
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<td>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.</td>
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<td>(b) Comprehensive Care Plans</td>
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<td>(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 following -</td>
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<td>(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</td>
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<td>(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).</td>
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<td>(iii) Any specialized services or specialized rehabilitative services the nursing facility will</td>
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Based on observation, interview and record review, the facility failed to initiate care plans related to a resident's broken and missing teeth, monitoring for an anticoagulant medication and monitoring for specific targeted behaviors for 3 of 23 residents reviewed for care plans (Resident 77 and 169).

Findings include:

1. On 06/06/2017 at 02:05 p.m., Resident 77 was observed to have her own teeth with missing and broken teeth on the top left side of her mouth.

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<td>F279-Develop Comprehensive Care Plans</td>
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It is the practice of this facility to develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Resident 77 has a dental care
Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

An Annual Minimum Data Set (MDS) Assessment dated 08/31/2016, was marked as "no natural teeth or tooth fragments" in the Section L - Oral/Dental Status. The Section V - Care Area Assessment (CAA) Summary, indicated "...Resident triggered for CAA due to she has no dentures or natural teeth, resident has no difficulty with chewing or swallowing. Resident denies oral pain. Resident states she has no oral sores, refused oral exam. Resident is able to enjoy foods per her choice and says she will not have dentures and does not need teeth to enjoy food. Resident does own oral care per her choice...Will proceed with a care plan...."

No care plan related to Resident 77's dental status was located.

During an interview on 06/12/2017 at 2:49 p.m., the MDS Assistant indicated the residents' dental status of broken and plan in place
Resident 169 has antiplatelet care plan in place
Resident 169 has a behavior monitoring care plan and flow sheet in place

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
All residents have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team of all residents to ensure a dental care plan is in place and all residents receiving antiplatelet medication to ensure a care plan is in place. Social Services will complete an audit of all residents receiving a psychotropic medication to ensure that a behavior flow sheet and care plan is in place.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
The Interdisciplinary Care Plan team will be in-serviced on or before 7/6/17 to review the facility policy related to development and implementation of person centered care plans for each resident. Care plans will be initiated if indicated, reviewed and updated to reflect each resident's status as indicated in the comprehensive assessment.
missing teeth should have been care planned.2. Resident 169's record was reviewed on 6/9/17 at 10:00 a.m. Diagnoses included, but were not limited to, Sick sinus syndrome, Chronic kidney disease, stage 4, Schizophrenia, other depressive episodes and ST elevation (STEMI) myocardial infarction.

Medications included, but were not limited to, Clopidogrel tablet 75 milligram (mg) by mouth (po) daily (an antiplatelet agent). Risperidone (antipsychotic) 6 mg po at bedtime. Paliperidone (antipsychotic) 12 mg po daily. Sertraline (antidepressant) 50 mg po at bedtime.

No care plan for antiplatelet side effect monitoring was located. No Behavior monitoring related to Schizophrenia or depression diagnoses were located.

A progress note dated 5/18/17, by the facility Psychiatric Providers Nurse Practitioner indicated "...Staff to monitor mood and behaviors for s/s [signs and symptoms] of depression or changes...."

During an interview on 6/9/17 at 10:50 a.m., the 2nd Floor Social Services Staff indicated Resident 169 was not currently being monitored, there were no behavior monitoring flow sheet in place and no Care plans are reviewed/initiated and updated by the IDT at admission, quarterly, annually, and with any change of condition.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The MDSC/designee will be responsible for completing the QAPI tools Care Plan Updating and Care Plan Review weekly for 4 weeks and then monthly for at least 6 months. The SSD/designee will be responsible for completing the QAPI tool Behavior Management weekly for 4 weeks and then monthly for at least 6 months. If threshold of 90% is not met for either QA tool, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
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<td>During an interview on 6/9/17 at 3:00 p.m., the MDS Coordinator indicated the resident did not have a care plan for monitoring of bleeding as it relates to antiplatelet therapy and it should have been in place.</td>
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<td>A current policy titled &quot;IDT [Interdisciplinary Team] Care Plan Review&quot; dated 4/14, obtained from the MDS Coordinator on 6/9/17 at 3:22 p.m., indicated &quot;...Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and references to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs. Procedure: Care Plan review will be based on the MDS schedule for those residents who have had an Admission, Annual, Significant Change or Quarterly MDS completed at a minimum of every 90 days... Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...&quot;</td>
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### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 06/13/2017

### Name of Provider or Supplier

**Rosewalk Village at Lafayette**

**Street Address, City, State, Zip Code:**

1903 Union St
Lafayette, IN 47904

### Summary Statement of Deficiencies

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**3.1-35(b)(1)**

#### F 0309
**SS=D**
**Bldg. 00**

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**483.24, 483.25(k)(l)**

**Provide Care/Services for Highest Well Being**

**483.24** Quality of Life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

**483.25** Quality of Care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices, including but not limited to the following:

**(k) Pain Management.**

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the
(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.

Based on observation, interview and record review, the facility failed to ensure daily weights were completed for a resident with a diagnosis of congestive heart failure and failed to ensure the physician was notified of weight changes as ordered (Resident 31) and failed to weigh a resident on dialysis per doctor's order for 1 of 1 resident reviewed for dialysis (Resident 139).

Findings include:

1. Resident 31’s record was reviewed on 06/8/2017 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, acute and chronic respiratory failure, type 2 Diabetes Mellitus, and heart failure.

A Quarterly Minimum Data Set Assessment dated 2/1/2017 Section I. Active Diagnoses indicated Resident 31 had an active diagnosis of heart failure.

A care plan for a therapeutic diet related to diabetes, congestive heart failure and comprehensive person-centered care plan, and the residents’ goals and preferences.

A care plan for a therapeutic diet related to diabetes, congestive heart failure and comprehensive person-centered care plan, and the residents’ goals and preferences.

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It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Resident 31 MD and family notified of resident weights
Resident 139 no longer resides at facility

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
Any resident requiring daily weights to be obtained has the potential to be affected by this finding. A facility audit will be completed by the IDT/Nurse Management Team for all residents that require daily weight monitoring. All residents
body weight was initiated on 8/12/2016. The goal was the "resident will have no significant weight changes."
Interventions included, but were not limited to, monitor food/fluid intake at meals, monitor weight, notify MD (medical doctor)/Family of significant weight changes.

A physician's order dated 8/3/2016, indicated the resident's weight should be obtained every day related to CHF (congestive heart failure) and to notify the MD of weight gain of 3 pounds in a day or 5 pounds in a week.

Review of Resident 31's "Documentation Administration History" for the order "Daily Weight for CHF" indicated from 4/12/2017 to 5/12/2017 the resident had not been weighed on 11 separate days; April 12, 13, 14, 15, and 21, as well as, May 1, 3, 5, 6, 7, and 11. Documentation from 5/13/2017 through 6/11/2017 indicated 3 days with no weight documentation.

On 4/19/2017 the resident weighed 348 pounds (a 7 pound weight gain). Documentation indicated the MD was not notified.

On 4/26/2017 the resident weighed 343.5 pounds. On 4/27/2017 the resident identified in this audit will have the last 30 days of weights reviewed and ensure MD notification has been completed for any resident with a change.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
The DNS/designee will in-service the nursing staff on obtaining daily weight and MD/family notification for changes on or before 7/6/17. Any resident requiring daily weights will have their weights reviewed daily by the DNS/designee to ensure that it was obtained and that notification has been completed if needed.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Change in Condition daily for 4 weeks and weekly for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Address:** 1903 UNION ST, LAFAYETTE, IN 47904

#### Summary Statement of Deficiencies

**ID** | **Prefix** | **Tag** | **Prefix** | **Completion Date**
--- | --- | --- | --- | ---
F 0312 | SS=D | Bldg. 00 | 483.24(a)(2) | 07/13/2017

**F 0312 - ADL Care Provided For Dependent Residents**

It is the practice of this facility that a resident who is unable to carry out activities of daily living is provided Activities of Daily Living (ADL) care for residents requiring extensive care.

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**Event ID:** 888111  **Facility ID:** 000051  **Page:** 45 of 113
assistance related to hair, foot care and showers for 2 of 4 residents reviewed for ADL care (Resident 77 and 31).

Findings include:

1. On 06/06/2017 at 02:05 p.m., Resident 77 was observed to be lying in her bed, the head of the bed was elevated and the resident was observed to have multiple matted sections in her hair.

Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

A Quarterly Minimum Data Set (MDS) Assessment dated 04/27/2016, indicated Resident 77 was an extensive assist and required one person physical assist with personal hygiene which was how she maintained her personal hygiene and included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands.

A review of Resident 77's shower sheets were as followed:

a. 05/15/2017 - Resident refused a

receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 77 preferences related to bathing, hair and nail care have been updated and identified on her ADL care plan and resident profile. Her hair has been washed and her toenails have been trimmed.

Resident 31 received a shower and his shower preference was updated and identified on his ADL care plan and resident profile.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

Any resident requiring assistance with grooming and personal hygiene have the potential to be affected by this finding. The care plan and resident profiles for all residents requiring assistance with ADL care such as hygiene, hair and nail care have been reviewed to ensure each resident specific need was accurately addressed. Changes in residents requiring ADL assistance will be reviewed quarterly during the care plan review process and/or with any noted change in resident condition.

What measures will be put into
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**By what date the systemic changes will be completed:**

Compliance Date: 7/13/17
## Statement of Deficiencies and Plan of Correction

### Identification Number:
- Multiple Construction
- A. Building
- B. Wing

### Date Survey Completed:
- 06/13/2017

### Name of Provider or Supplier:
- Rosewalk Village at Lafayette
  - 1903 Union St
  - Lafayette, IN 47904

### Summary Statement of Deficiencies:

#### Prefix Tag

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<th>Provider's Plan of Correction</th>
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- **h. 06/08/2017** - Resident refused a shower and a complete bed bath was given. Linens were changed. Shampoo and nail care was not marked as being given.

A facility document titled "A.M. Care" dated 04/2012, received from the Administrator on 06/12/2017 at 3:13 p.m., indicated "...10. Comb and style resident's hair...15. Document and report any pertinent information...."

A review of the CNA's Point of Care Charting from 05/12/2017 to 06/11/2017 indicated the following:

- **a. On 05/14/2017** - AM care was not marked as being completed.
- **b. On 05/17/2017** - AM and PM care was not marked as being completed.
- **c. On 05/19/2017** - AM care was not marked as being completed.
- **d. On 05/20/2017** - AM care was not marked as being completed.
- **e. On 05/24/2017** - AM care was not marked as being completed.
- **f. On 05/28/2017** - AM care was not marked as being completed.
- **g. On 06/01/2017** - PM care was not marked as being completed.
- **h. On 06/02/2017** - AM care was not marked as being completed.
- **i. On 06/03/2017** - AM and PM care was not marked as being completed.
Resident 77's Care Plan dated 12/23/2010, addressed the problem the resident had a distinct preference related to clothing, personal belongings and religious services. Interventions included, but were not limited to, "...12/23/2010-Allow resident choice when choosing clothing, shoes and the way she wears her hair...."

Resident 77's Care Plan dated 04/10/2015, addressed the problem the resident required assistance and/or monitoring for ADL care, meal/fluid intakes and bowel elimination. Interventions included, but were not limited to, "...04/10/2015- Tasks: AM care including bathing, dressing, hair combing and oral care, Tasks: PM care including bathing, dressing, hair combing and oral care.

During an interview on 06/12/2017 at 10:49 a.m., Resident 77 indicated she was supposed to receive bed baths on Tuesday and Friday but they did not get
completed as scheduled. She indicated "the nurses will not let the CNAs stay in the room long enough to give her bed baths or help with her hair."

On 06/12/2017 at 11:49 a.m., during an observation with the Director of Nursing (DON) Resident 77 was observed to have matted hair in 4 areas on the sides and back of her head. The matted areas were approximately one quarter of an inch away from the resident's scalp. At this time during an interview the DON indicated there were 4 matted areas in Resident 77's hair and each area measured approximately the size of the palm of a hand.

During an interview on 06/12/2017 at 11:50 a.m., Resident 77 indicated she had not had her hair washed in months. She indicated she needed a better brush because when she tried to use the brush the facility gave her, the bristles would just break off in her hair. At that time, Resident 77 was observed to be in tears and indicated she was scared she may have to have her head shaved to remove the matted areas. Resident 77's left foot was observed to be dry with yellow scales covering the foot. Her toenails were thick, yellow and were grown out so long they had curled over the tip of her toes and into the skin on the bottom of
During an interview on 06/12/2017 at 12:03 p.m., the DON indicated she was not previously aware of the matted areas in Resident 77's hair.

During an interview on 06/12/2017 at 2:15 p.m., the Administrator indicated Resident 77 preferred a bed bath however a CNA could complete a shampoo during a bed bath. He indicated he was unaware of the condition of Resident 77's toenails being as long as they were and even if a resident refuses to see a podiatrist, the facility should address residents' toenails.

During an interview on 06/13/2017 at 8:30 a.m., the Administrator indicated he could not locate a policy related to hair care or foot care.

On 06/13/2017 at 9:14 a.m., Resident 77 was observed to have the matted areas on both sides of her head removed. The matted areas directly on the back of the head remained. At that time, Resident 77 indicated the facility beautician worked on removing the matted areas from the sides of her hair and was supposed to come back to continue to work on the back of her head. She indicated she had considered having her hair cut and colored so she would feel better about her toes.
During an interview on 06/13/2017 at 10:04 a.m., CNA 1 indicated Resident 77 told her she could do her own oral care and hair brushing; therefore, she does not provide that care. She indicated she was unaware Resident 77's hair was matted.

A facility document titled "Certified Nursing Assistant (CNA) Position Description" dated 10/2014, received from the Director of Nursing on 06/09/2017 at 3:19 p.m., indicated "...Grooming- Shaves, trims, shampoos, and combs hair of residents as instructed. Clean and soaks fingers and toenails (as instructed) before trimming. Assists residents with oral hygiene as instructed...."

A facility document titled "Skills Validation-CNA Comb Hair" dated 03/2012, received from the Administrator on 06/13/2017 at 9:43 a.m., indicated "...Raise head of bed so resident is sitting up...Remove tangles by dividing hair into small sections and gently combing out from end of hair to scalp...Report any unusual findings to charge nurse...."

Resident 31's record was reviewed on 06/8/2017 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, acute and
chronic respiratory failure, type 2
Diabetes Mellitus, and heart failure.

During an interview on 6/08/2017 at 8:52 a.m., Resident 31 indicated he did not get his showers and he preferred to have showers at night before going to bed.

During an interview on 6/09/2017 at 9:05 a.m., Resident 31 indicated his last shower was over a week ago.

A Quarterly Minimum Data Set dated 2/1/2017, indicated the resident had a Brief Interview for Mental Status score of 15. Section G-Functional Status, ADL Assistance, J. Personal Hygiene was marked as extensive assistance. Total dependence was marked for Bathing, Self Performance.

Care plans include, but are not limited to, the "resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: impaired mobility, chronic pain, impaired gait, use of assistive device, (sic) and impaired vision (sic)." The goal indicated the resident will assist with ADL's to ability. Interventions included, but were not limited to, "provide shower two times per week, partial bath in between, Prefers PM shower."
Review of the "Point of Care History" for Resident 31 indicated he had 1 shower in the month of April (4/29/2017), 3 showers in the month of May (5/6/2017, 5/16/2017, and 5/30/2017), and as of 6/8/2017, Resident 31 had 0 showers in the month of June.

Review of the "Shower Report", also known as "Shower Sheets", received by UM 2 on 6/9/2017 at 12:47 p.m., indicated the resident had three showers in the month of May.

Review of a "Concern/Grievance Form" for Resident 31 dated 5/24/2017 indicated the resident "is not getting his 2 baths every week...." The response of the grievance dated 5/30/2017 indicated UM 2 spoke with the resident and staff were to bathe him upon rising in the morning.

At the time of exit conference, the facility was unable to produce a policy for resident showers.

3.1-38(a)(3)(B)  
3.1-38(b)(3)  

F 0314 483.25(b)(1)
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Based on interview and record review, the facility failed to assess a pressure wound for 1 of 3 residents reviewed for pressure wounds (Resident 114).

Finding includes:

Resident 114's closed record was reviewed on 6/8/17 at 3:03 p.m. Diagnoses included, but were not limited to, stage I pressure wound, Parkinson's disease and dementia.

A Care Plan dated 4/14/17, indicated Resident 114 had a stage I pressure wound to the sacrum and the staff would assess the wound weekly and document the measurements and the description of the wound.

The wound notes indicated the measurements for the stage I pressure wound to the sacrum were
completed on 4/14/17, 4/18/17 and 4/25/17.

During an interview on 6/13/17 at 10:54 a.m., the Nurse Consultant indicated there were no wound measurements completed after 4/25/17 and should have been completed weekly including 5/2/17 and 5/9/17.

A current policy titled "Skin Management Program" dated 9/2016, received from the Director of Nursing on 6/9/17 at 3:22 p.m. indicated "...The facility must have an assigned wound nurse that assesses the wounds on a weekly basis...The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day...Wound management for ulcers [arterial, diabetic, pressure or venous]...updated weekly until resolved...."

3.1-40(a)(1)

identified and what corrective action(s) will be taken: Any resident that has pressure areas that require weekly assessment has the potential to be affected by this finding. All residents that currently reside in the facility with pressure wounds have been audited for the last 30 days to ensure that weekly measurements have been completed.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DNS/designee will in-service IDT/facility assigned wound nurse on facility Skin Management Policy related completing weekly assessment and measurements of wounds. DNS/designee will audit residents with wounds to ensure measurements have been obtained on a weekly basis.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool Skin Management Program daily for 4 weeks and weekly for at least 6 months. If threshold of 90% is
483.25(d)(1)(2)(n)(1)-(3)
FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES
(d) Accidents. The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed’s dimensions are appropriate for the resident’s size and weight.
Based on observation, interview and record review, the facility failed to ensure a resident's room was free of accident hazards, failed to complete smoking risk assessments and failed to follow facility policy regarding the type of electronic cigarettes allowed in the facility for 4 of 4 residents reviewed for accidents (Resident 70, 77, 32 and 75).

Findings include:

1. On 06/07/2017 at 11:22 a.m., a six plug power strip with Resident 70's tabletop fan and electronic cigarette charger plugged into it was observed to be laying on the foot of her bed. At that time, Resident 70 indicated she kept it on her bed at all times including while she sleeps so she could reach it easier. She indicated she "checks it" before she goes to sleep "to make sure it is okay." She indicated she did not want it on the floor due to "housekeeping may get it wet with the mop and ruin my electronic cigarette charger."

During an interview on 06/07/2017 at 11:38 a.m., the Administrator indicated he was not aware of the power strip being kept on the residents bed. At that time, he unplugged the electronic cigarette charger from the power strip and plugged it directly into the wall and then placed the
power strip under the bed with the fan still plugged into the strip. He indicated to the resident if it did not work for her, he would look for another option.

Resident 70's record was reviewed on 06/09/2017 at 1:20 p.m. Diagnoses included, but were not limited to, muscle weakness, respiratory failure, dementia without behavioral disturbance, schizophrenia, bipolar disorder, anxiety disorder and nicotine dependence.

A Physician's Order dated 12/16/2015, indicated the resident could have an electronic cigarette at bedside.

Resident 70's care plan addressed the problem the resident uses an electronic cigarette. Interventions included, but were not limited to, "...12/17/2015- IDT [Interdisciplinary Team] to assess resident's ability to use the electronic cigarette upon admission/quarterly or upon a significant change...."

No smoking assessments for Resident 70 were located in her record.

On 06/07/2017 at 03:38 p.m., the Administrator indicated the facility had switched out the power strip to one with a longer cord and had attached the power strip to the underside of Resident 70's

Facility audit of all rooms will be completed to assess for potential hazards. All residents that utilize electronic cigarettes have been provided with an allowable device. All residents that utilize electronic cigarettes have been audited to ensure assessments are up to date.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
ED/designee will in-service all staff on or before 7/6/17 on potential hazards. ED/designee will educate Social Services on Electronic Cigarette Policy on or before 7/6/17. ED/designee will complete safety rounds checking for potential hazards daily for 4 weeks and then weekly thereafter for at least 6 months. Social Service will complete smoking assessments for any resident utilizing an electronic cigarette upon admission, quarterly, and/or with any significant change.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). Maintenance Department will complete the QA tool labeled Dignity and Privacy/ Environment
bedside table in order for the resident to be able to reach the plugs without keeping it in her bed.

During an interview on 06/09/2017 at 10:11 a.m., the Social Service Director (SSD) indicated smoking risk assessments should be completed on admission, quarterly or with a significant change and Resident 70 had not had an assessment completed on admission or quarterly after admission.

During an interview on 06/09/2017 at 10:43 a.m., Resident 70 indicated she placed the power strip in her bed about two weeks ago. She indicated about two months ago her Customer Care Coordinator came to her room for a visit and she had her fan and charger plugged into an extension cord. The Customer Care Coordinator felt the extension cord was unsafe and asked her to unplug it and she did. Resident 70 indicated the Maintenance Assistant then brought her the power strip.

During an interview on 06/09/2017 at 2:04 p.m., Resident 70's Customer Care Coordinator indicated she went into the resident's room and had observed the resident was using an extension cord that ran under the bed and over the bed side table. She indicated she tripped over it of Care weekly for 4 weeks and then monthly for 6 months. The Social Service Department will complete the QA tool labeled Smoking Policy weekly for 4 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. 

By what date the systemic changes will be completed: Compliance Date: 7/13/17
and she told the resident it was not safe to have it placed in her room and over the bedside table due to it was a tripping hazard. She indicated the resident told her she would call her son and return it to him. She indicated she could not remember if she followed up on the issue after she left the resident's room that day.

During an interview on 06/09/2017 at 2:18 p.m., the Maintenance Assistant indicated about two months ago he put the power strip into Resident 70’s room. He indicated he placed it under the bed and plugged her items into the outlets for her.

On 06/12/2017 at 3:35 p.m., with the Administrator in attendance, Resident 70 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.

2. Resident 77’s record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia
and insomnia.

A Physician's Order dated 08/31/2016, indicated the resident may use an electronic cigarette.

Resident 77's care plan addressed the problem the resident wishes to use an electronic cigarette. Interventions included, but were not limited to, "...05/06/2013- Assess for safety awareness r/t [related to] smoking an electronic cigarette...."

No smoking assessments for Resident 77 were located.

During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 77 had not had a smoking risk assessment completed since 12/2014.

On 06/13/2017 at 8:54 a.m., with the Administrator in attendance, Resident 77 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.

3. Resident 32's record was reviewed on 06/12/2017 at 2:00 p.m. Diagnoses
## Statement of Deficiencies and Plan of Correction

### Identification Number:
MULTIPLE CONSTRUCTION
06/13/2017

### Name of Provider or Supplier:
ROSEWALK VILLAGE AT LAFAYETTE
1903 UNION ST
LAFAYETTE, IN 47904

### Summary Statement of Deficiencies

Inclusion, but not limited to, malignant neoplasm of an unspecified part of the bronchus or lung, alcohol dependence, personal history of nicotine dependence, asthma, dementia with behavioral disturbance, heart failure, depressive episodes and anxiety disorder.

A Physician's Order dated 12/31/2015, indicated the resident may have an electronic cigarette due to nicotine anxiety.

Resident 32's care plan addressed the problem the resident used an electronic cigarette. Interventions included, but were not limited to, "...12/31/2015- IDT to assess resident's ability to use the electronic cigarette upon admission/quarterly or upon a significant change...."

No smoking assessments for Resident 32 were located.

On 06/12/2017 at 3:39 p.m., with the Administrator in attendance, Resident 32 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.
During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 32 had a smoking risk assessment completed on 05/31/2017 for the first time since being admitted to the facility.

4. Resident 75's record was reviewed on 06/12/2017 at 2:50 p.m. Diagnoses included, but were not limited to, cough, insomnia, depressive episodes, anxiety, obstructive sleep apnea and chronic obstructive pulmonary disease.

A Physician's Order dated 11/20/2014, indicated the resident may have an electronic cigarette at bedside.

Resident 75's care plan addressed the problem the resident chose to use an electronic cigarette while at the facility. Interventions included, but were not limited to, "...04/15/2013- Do smoking risk assessment...."

No smoking assessments for Resident 75 were located.

On 06/12/2017 at 3:42 p.m., with the Administrator in attendance, Resident 75 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on
During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 75 had a smoking risk assessment completed on 05/16/2017 and the last previous assessment was completed 12/17/2014.

During an interview on 06/13/2017 at 8:54 a.m., the Administrator indicated Social Services would be the department to complete the smoking risk assessments initially, quarterly and with a significant change according to the facility policy. He indicated he was not aware the facility policy discussed only using a certain type of electronic cigarettes. He indicated the residents had always used the liquid version of the electronic cigarette.

A current facility policy titled "Electronic Cigarettes" dated 04/2016, received from the Administrator on 06/09/2017 at 12:25 p.m., indicated "...Allowable electronic cigarettes include those that are self contained or use cartridges; those that use liquid nicotine are not permitted...Each resident requesting to use an electronic cigarette must be screened at admission and/or quarterly, or any significant change, by the IDT team...."
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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| 3.1-45(a)(2) | 483.25(g)(1)(3) | MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE | (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident’s comprehensive assessment, the facility must ensure that a resident-
(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;
(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to recognize a significant weight loss and implement interventions for 2 of 3 residents reviewed for nutrition. (Residents 74 and 166). Resident 74 had 7.3% weight loss in 20 days and Resident 166 had a 6.3% weight loss in 15 days. Findings include:
1. Resident 74's closed record was reviewed on 6/9/17 at 11:10 a.m. Diagnoses included, but were not limited to, colostomy, hypertension and

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<th>F325-Maintain Nutrition Status Unless Unavoidable</th>
<th>07/13/2017</th>
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malignant neoplasm of endometrium.

A physician order dated 3/17/17, indicated a regular/cardiac diet.

A care plan dated 3/28/17, indicated the resident required a therapeutic diet related to hypertension and the resident's usual body weight was 175 to 185 pounds. The care plan goal was to maintain the resident's weight within the usual body weight and the approaches included, but were not limited to, monitor weight and notify physician of significant weight changes.

The weight log indicated the following weights for Resident 74:
- On 3/17/17 the resident weighed 178.8 pounds.
- On 3/28/17 the resident weighed 178 pounds.
- On 4/06/17 the resident weighed 166 pounds.
- On 4/17/17 the resident weighed 164 pounds.

A Registered Dietician (RD) progress note dated 4/19/17, indicated the resident triggered for a significant weight loss and the weight loss was likely due to cancer treatments. The RD recommended fortified milk at breakfast and lunch and ice cream at dinner.

During an interview on 6/13/17 at 10:47 a.m., the Nurse Consultant indicated the physician was not notified of the significant weight loss on 4/06/17 and no interventions were in place until 4/19/17 when the weight loss was reviewed by the dietician.

2. Resident 166's closed record was reviewed on 6/08/17 at 1:19 p.m. Diagnoses included, but were not limited to, dementia, hypertension and anxiety.

A physician order dated 1/11/17, indicated otherwise.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
- Resident 74 no longer resides at the facility
- Resident 166 no longer resides at the facility

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
Any resident at risk for significant weight loss has the potential to be affected by this finding. The Nurse Management Team will be responsible for completing a facility audit to review all residents at risk for significant loss and those that have experienced significant weight loss to ensure that the resident’s MD and family have been notified and interventions were initiated.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
DNS/designee will conduct a nursing in-service to review facility policy related to weight management and review of residents with weight and nutritional concerns. The DNS/designee will be responsible for reviewing and monitoring weight changes to ensure that
regular diet with soft foods.

A care plan dated 1/11/17, indicated the resident required assistance with ADL (activities of daily living) including meal and fluid intake. The goal was for the resident to have ADL needs met and approaches included, but were not limited to, documenting percentages of food and fluid intake at breakfast, lunch and dinner.

The weight log indicated the following weights for Resident 166:
- On 1/11/17 the resident weighed 160 pounds.
- On 1/18/17 the resident weighed 158 pounds.
- On 1/26/17 the resident weighed 150 pounds.
- On 1/31/17 the resident weighed 144 pounds.

An RD note dated 1/26/17, indicated the resident weighed 150 pounds on 1/26/17 and 160 pounds on 1/11/17 and no significant weight changes, yet weight was trending down. Bilateral edema was noted in the observation and the recommendation was to continue the current care plan.

An IDT (interdisciplinary team) progress note dated 2/2/17, indicated the resident had lost 6 pounds and the resident was moved to a smaller dining area due to her anxiety at meal times.

During an interview on 6/9/17 at 10:20 a.m., the Director of Nursing (DNS) indicated the IDT meets every week and reviews the residents that have lost 5 pounds or more. The DNS did not know the reason the resident was not identified as having a significant weight loss during the IDT meeting and during the RD review.

A current policy titled "Resident Weight Monitoring" dated 1/2016, received from the Administrator on 6/12/17 at 2:08 p.m. indicated "..."...It is the policy of this facility to have any resident with a significant weight change is reviewed and intervention is put into place if needed.

**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). DNS/designee will complete the QA tool Resident Weights weekly for 4 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

**By what date the systemic changes will be completed:**
Compliance Date: 7/13/17
resident weights reviewed routinely by the Registered Dietician and The Nursing Department. An interdisciplinary team will review any resident who has weight or nutritional concerns...The interdisciplinary team will place the following residents on a weekly weights...Residents who have experienced a significant weight loss or gain of 5% in 30 days, 7.5% in 90 days or 10% in 180 days...."

3.1-46(a)(1)

483.45(d)(e)(1)-(2)
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--
(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

Based on interview and record review, the facility failed to monitor for specific targeted behaviors, side effects of an anticoagulant medication and failed to complete and follow through on Gradual Dose Reductions (GDR) related to the tapering of an antidepressant and antianxiety medications for 3 of 6 residents reviewed for unnecessary medications (Resident 82, 169 and 1).

Findings include:

1. Resident 82's record was reviewed on 06/08/2017 at 12:52 p.m. Diagnoses included, but were not limited to, insomnia, Type 2 Diabetes, anxiety disorder and depressive episodes.

A Physician's Order dated 07/08/2016, indicated Prozac (an antidepressant medication) give 20 mg (milligram) every day at bedtime and Xanax (an
antianxiety medication) give 0.25 mg three times a day.

Resident 82's care plan dated 07/08/2016, addressed the problem the resident was at risk for adverse side effects related to the use of psychotropic medications (antidepressant and antianxiety). Interventions included, but were not limited to, "... 07/08/2016- IDT [Interdisciplinary Team] to review routinely to attempt gradual dose reductions, unless contraindicated by MD/NP...."

During an interview on 06/12/2017 at 4:30 p.m., the Social Service Director (SSD) indicated she could not find any pharmacy recommendations regarding GDR's of Resident 82's psychotropic medications.

During an interview on 06/13/2017 at 11:13 a.m., the Nurse Consultant indicated Resident 82 should have been reviewed for her psychotropic medications by this time and a GDR should have been attempted. She indicated the SSD was new and the resident would be reviewed at the next meeting in June and the Medical Doctor would be approached for a GDR.

During an interview on 06/13/2017 at

potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
Any resident receiving psychotropic medication or antiplatelet medication has the potential to be affected by this finding. Facility audit will be completed by DNS/designee for all residents receiving antiplatelet medication to ensure a care plan is in place. Social Services will complete an audit of all residents receiving a psychotropic medication to ensure that a GDR has been reviewed, behavior flow sheet and care plan is in place.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
DNS/designee will complete nursing in-service on or before 7/6/17 to review facility policy related to Psychoactive Medication Management Program and monitoring for side effects related antiplatelet medications. DNS/designee will review all new orders daily for psychotropic medications and antiplatelet medications to ensure side effect monitoring is in place and behavior monitoring is in place.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
DNS/designee will complete nursing in-service on or before 7/6/17 to review facility policy related to Psychoactive Medication Management Program and monitoring for side effects related antiplatelet medications. DNS/designee will review all new orders daily for psychotropic medications and antiplatelet medications to ensure side effect monitoring is in place and behavior monitoring is in place.
11:19 a.m., the SSD indicated the IDT behavior meetings for psychoactive medications were completed monthly. During those meetings behavior flow sheets were reviewed and a form was filled out to determine the number of behaviors during the month and whether or not a GDR should have been attempted. The meeting included the Pharmacy Consultant, the NP and a Counselor from the facility's psychiatric services and the SSD and unit manager from the facility. She indicated Resident 82 was tracked for behaviors in August, September and October of 2016 and was not monitored for the following months. She indicated she "was not sure what had happened." However, behavior tracking for Resident 82 was put back into place in May and she would be reviewed in June at the IDT meeting and considered for a GDR.

2. The record for Resident 1 was reviewed on 6/9/2017 at 9:13 a.m. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, muscle weakness, depression, and hydrocephalus.

Medications for Resident 1 included, but were not limited to, Buspirone (antidepressant) 15 milligram (mg) tablet twice a day. Trazodone (antidepressant) 75 mg at night. Phenobarbital.
(antiseizure medication) 64.8 mg twice a day upon rising and at bed time.

A physician's order for Buspirone 15 mg twice a day was received on 8/20/2016.

A GDR for Resident 1 dated 2/14/2017 indicated a recommendation of decreasing Buspirone 15 mg BID (twice a day) to Buspirone 10 mg BID. The recommendation as accepted and the order was signed 2/28/2017.

During an interview on 6/13/2017 at 8:59 a.m. UM 2 indicated the GDR was accepted 2/28/2017 by the Nurse Practitioner but that she did not see where the GDR was actually done.

Resident 169's record was reviewed on 6/9/17 at 10:00 a.m. Diagnoses included, but were not limited to, Sick sinus syndrome, Chronic kidney disease, stage 4, Schizophrenia, other depressive episodes, and ST elevation (STEMI) myocardial infarction.

Medications included, but were not limited to, Clopidogrel tablet 75 milligram (mg) by mouth (po) daily (an antiplatelet agent), Risperidone (antipsychotic) 6 mg po at bedtime, Paliperidone (antipsychotic) 12 mg po daily, Sertraline (antidepressant) 50 mg po at bedtime.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ID: 155121
MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

DATE SURVEY COMPLETED: 06/13/2017

NAME OF PROVIDER OR SUPPLIER
ROSEWALK VILLAGE AT LAFAYETTE
1903 UNION ST
LAFAYETTE, IN 47904

<table>
<thead>
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<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>3.1-48(b)(1)</td>
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<td>No care plan for antiplatelet side effect monitoring was located. No Behavior monitoring related to Schizophrenia or depression diagnoses were located.</td>
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<td>3.1-48(b)(2)</td>
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<td>A progress note dated 5/18/17, by the facility Psychiatric Providers Nurse Practitioner indicated &quot;...Staff to monitor mood and behaviors for s/s [signs and symptoms] of depression or changes....&quot;</td>
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<td>During an interview on 6/9/17 at 10:50 a.m., the 2nd Floor Social Services Staff indicated Resident 169 was not currently being monitored, there were no behavior monitoring flow sheet in place and no behavior care plan at this time.</td>
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<td>During an interview on 6/9/17 at 3:00 p.m., the MDS Coordinator indicated the resident did not have a care plan for monitoring of bleeding as it relates to antiplatelet therapy and it should have been in place.</td>
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<td>At time of exit, no policy regarding psychoactive medications was provided.</td>
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<td>F 0334</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</td>
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(d) Influenza and pneumococcal immunizations

(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 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.
(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 administer a Pneumococcal vaccine as required for 1 of 5 residents being reviewed for immunizations (Residents 77).

Finding includes:

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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 0334</td>
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<td>F334-Influenza and Pneumococcal Immunizations</td>
<td>07/13/2017</td>
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It is the practice of this facility to offer a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.
1. Resident 77's record was reviewed on 6/12/2017 at 3:45 p.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disorder, fracture of left wrist and hand, chronic respiratory failure, and edema.

   Resident 77's "Pneumococcal Vaccination Consent for PPSV23 and PCV13" (PPSV23 is a pneumococcal polysaccharide vaccine that protects against 23 types of pneumococcal bacteria and PCV13 is a pneumococcal conjugate vaccine that protects against 13 types of pneumococcal bacteria) was signed on 6/5/2017, indicating "I give permission for the administration of the Pneumococcal vaccine PPSV23 or PCV13." A handwritten note on the consent indicated "needs the PPSV23."

   A physician's order for the Pneumovax 23 was received on 6/8/2017 with a start date of 6/9/2017 at 6:00 a.m. and an end date of 6/9/2017 at 2:00 p.m.

   Review of the Electronic Medication Administration Record indicated that the vaccine was not given on 6/9/2017.

   During an interview on 6/12/2017 at 4:01 p.m., UM 1 indicated Resident 77 was not administered the vaccination and the

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

   Resident 77 was given the pneumococcal immunization and MD was notified

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

   All residents have the potential to be affected by this finding. Facility audit of all residents currently residing in the facility has been completed to ensure that the resident has been offered and provided the pneumococcal immunization if indicated.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

   In-service for nurses will be completed on or before 7/6/17 by the DNS/designee related to facility policy on pneumococcal immunizations. Pneumococcal immunization status will be reviewed daily in clinical meeting for those residents in assessment.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
A current policy titled "Pneumococcal Vaccination" last reviewed 8/2016, received during entrance conference from the Director of Nursing, indicated: "Policy: It is the policy of this facility that resident(s) will be offered pneumococcal vaccination (if appropriate) to help prevent the development and transmission of pneumonia...Procedure: 8. Pneumonia vaccine administration procedure: a. Verify resident and physician order b. Verify absence of allergies per pharmaceutical recommendations c. Obtain baseline vital signs prior to administration of vaccine. d. Do Not vaccinate the resident with acute febrile illness until symptoms resolve. e. Administer vaccine, intramuscularly in deltoid muscle. f. Document in electronic medication record...."

3.1-13(a)(1)

F 0353
SS=D
Bldg. 00

483.35(a)(1)-(4)
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS
483.35 Nursing Services

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services.
to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs.
Based on observation, interview and record review, the facility failed to ensure sufficient staff were available to complete showers, foot care and hair care for two residents needing extensive assistance with ADL's (activities of daily living) for 2 of 4 residents reviewed for ADL's (Residents 31 and 77).

Findings include:

1. Resident 31's record was reviewed on 06/8/2017 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, acute and chronic respiratory failure, type 2 Diabetes Mellitus, and heart failure.

During an interview on 6/08/2017 at 8:52 a.m., Resident 31 indicated he did not get his showers and he prefers to have showers at night before going to bed.

During an interview on 6/09/2017 at 9:05 a.m., Resident 31 indicated his last shower was over a week ago.

A Quarterly Minimum Data Set dated 2/1/17, indicated the resident had a Brief Interview for Mental Status score of 15. Total dependence was marked for Bathing, Self performance.

Care plan interventions included, but...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** ROSEWALK VILLAGE AT LAFAYETTE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1903 UNION ST, LAFAYETTE, IN 47904

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</td>
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<td>were not limited to, &quot;provide shower two times per week, partial bath in between, Prefers PM shower.&quot;</td>
<td></td>
<td>hair and nail care have been reviewed to ensure each resident specific need was accurately addressed. All residents shower preference was obtained and shower schedules updated. ED/designee will complete audit on staffing for all shifts to ensure that sufficient staff is scheduled. <strong>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</strong> Nursing in-service on resident preference will be held on or before 7/6/17. ED/designee will talk to residents about their preferences in resident council meeting. Residents preferences will be obtained upon admission and quarterly thereafter and/or updated at their request. DNS/designee will in-service all nursing staff on or before 7/6/17 to review facility practice on providing ADL care such as hygiene, hair and nail care. The DNS/designee will conduct rounds daily to ensure that residents are receiving ADL assistance as identified in their individual plan of care and that resident preferences are being honored. <strong>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</strong> Ongoing compliance with this corrective action will be monitored</td>
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During an interview on 6/9/17 at 3:53 p.m., the Administrator indicated the facility may need to look at staffing levels in regards to residents getting showers completed.

During an interview on 6/12/17 at 9:26 a.m., CNA 3 indicated she was not able to complete the duties which need to be done and the next shift was notified of duties not completed and then it was their job to complete.

During an interview on 6/12/16 at 3:01 p.m., CNA 2 indicated she was usually assigned 2 or 3 baths or showers to

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Additional text regarding the survey process and corrections made is provided in the document, but the focus is on the deficiencies and the corrective actions planned to address them. The document outlines the steps taken to ensure that the deficiencies do not recur and the measures in place to monitor the corrective actions.
complete each shift and sometimes 4. She also indicated about once a week she cannot get the baths or showers assigned to her completed and would inform the nurse.

2. On 06/06/2017 at 02:05 p.m., Resident 77 was observed to be lying in her bed, the head of the bed was elevated and the resident was observed to have multiple matted sections in her hair.

Resident 77’s record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

A Quarterly Minimum Data Set (MDS) Assessment dated 04/27/2016, indicated Resident 77 was an extensive assist requiring a one person physical assist with personal hygiene which was how she maintained her personal hygiene and included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands.

Resident 77's Care Plan dated 04/10/2015, addressed the problem the resident required assistance and/or
monitoring for ADL care. Interventions included, but were not limited to, "...04/10/2015- Tasks: AM care including bathing, dressing, hair combing and oral care, Tasks: PM care including bathing, dressing, hair combing and oral care.

During an interview on 06/12/2017 at 10:49 a.m., Resident 77 indicated she was supposed to receive bed baths on Tuesday and Friday but they did not get completed as scheduled. She indicated "the nurses will not let the CNAs stay in the room long enough to give her bed baths or help with her hair."

During an interview on 06/12/2017 at 11:50 a.m., Resident 77 indicated she had not had her hair washed in months. Resident 77's left foot was observed to be dry with yellow scales covering the foot. Her toenails were thick, yellow and were grown out so long they had curled over the tip of her toes and into the skin on the bottom of her toes.

During an interview on 06/12/2017 at 12:03 p.m., the DON indicated she was not aware of the matted areas in Resident 77's hair.

During an interview on 06/12/2017 at 2:15 p.m., the Executive Director indicated Resident 77 prefers a bed bath
however a CNA could complete a shampoo during a bed bath. He indicated he was unaware of the condition of Resident 77's toenails being as long as they were and even if a resident refuses to see a podiatrist, the facility should address residents' toenails.

A facility policy regarding staffing was not provided.

3.1-17(b)

483.60(i)(1)-(3)

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
- MULTIPLE CONSTRUCTION
- 00

#### Date Survey Completed:
- 06/13/2017

#### Name of Provider or Supplier:
- ROSEWALK VILLAGE AT LAFAYETTE
- 1903 UNION ST
- LAFAYETTE, IN 47904

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Summary statement of deficiencies</th>
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</table>
| F 0371 | - | - | (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to ensure expired foods were discarded and foods were labeled and dated when opened in 1 of 1 kitchens. This had the potential to affect 123 of 124 residents who received food from the kitchen. Findings include: During the kitchen tour on 6/6/17 at 9:55 a.m., with the Dietary Manager in attendance the following were observed: 1. Walk in freezer:
  a. One package of chicken leg quarters approximately 18 pieces, out of the original container and were not dated.
  b. Two packages of streusel bread out of the original container and were not dated.
  2. Main Kitchen area:
  a. One can of cooking spray opened, no lid and was not dated.
  b. One 4 ounce container of leaf tarragon was opened, not dated and had a shipping date of 4/7/16.
  c. One 11 ounce container of parsley flakes was opened and not dated.
  d. One 17 ounce container of ground |

#### Provider's Plan of Correction

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<th>ID</th>
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<th>Completion Date</th>
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<tbody>
<tr>
<td>F371</td>
<td>Food Procure, Store/Prepare/Serve-Sanitary</td>
<td>07/13/2017</td>
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</table>

- It is the practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.
- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**
  - No residents were affected by this finding. All items not dated or out dated were discarded immediately.
- **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**
  - All residents have the potential to be affected by this finding. The Dietary Manager/designee will complete a facility audit to ensure that all food items have been marked appropriately with date opened. Any expired or undated food items will be discarded. The Dietary Manager/designee will complete weekly food storage audits to ensure that items are dated appropriately or discarded as needed.
- **What measures will be put into place or what systemic**
### Summary Statement of Deficiencies

**a.** A one pound package of shredded mozzarella cheese was opened and not dated.

**b.** One clear plastic container with 15 pre-boiled, pre-peeled eggs with a label marked lettuce 6/3 and use by 6/10.

**c.** One clear plastic container of two diced boiled eggs was not dated.

**d.** One plastic container of diced tomatoes was not dated.

**e.** One plastic container of a half pound of diced ham was dated 6/1 and use by 6/8.

### Provider's Plan of Correction

**Changes will be made to ensure that the deficient practice does not recur:**

- ED/designee will in-service Dietary Staff on facility policy related to Food Storage practices, dating opened food items and discarding food items that are opened and undated on or before 7/6/17.

**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**

- Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).
- Dietary Manager/designee will complete the Short Sanitation check list daily for 4 weeks, weekly for 4 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

**By what date the systemic changes will be completed:**

- Compliance Date: 7/13/17
Manager on 6/7/17 at 11:22 a.m. indicated ... All opened and leftover items need to be labeled with the date of opening/date stored and a discard/use by date...Processed meats and any item that has been cooked and cooled should be kept no longer than 3 days. Label with the date of storage and the date of discard...."

3.1-21(i)(1)

483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities

The facility-

(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:

(i) Routine dental services (to the extent covered under the State plan); and

(ii) Emergency dental services;

(b)(2) Must, if necessary or if requested, assist the resident-

(i) In making appointments; and

(ii) By arranging for transportation to and from the dental services locations;

(b)(5) Must assist residents who are eligible
and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.

Based on observation, interview and record review, the facility failed to follow through with a dental referral to an offsite clinic after a complaint of discomfort for 1 of 3 residents reviewed for dental services (Resident 77).

Finding includes:

On 06/06/2017 at 02:05 p.m., Resident 77 was observed to have her own teeth with missing and broken teeth on the top left side of her mouth.

Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

An Annual Minimum Data Set (MDS) Assessment dated 08/31/2016, was marked as "no natural teeth or tooth fragments" in the Section L- Oral/Dental Status. The Section V- Care Area Assessment (CAA) Summary, indicated "...Resident triggered for CAA due to she has no dentures or natural teeth, resident.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 77 had an oral assessment completed with MD and family notification being completed. Referral to an outside dental provider was scheduled. On-site facility dentist reassessed resident 6/29/17. A dental care plan for Resident 77 is in place.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

All residents have the potential to be affected by this finding. The IDT will complete a facility audit and review each resident's clinical record for any recommendations requiring further follow up. The IDT will also complete a facility audit to review all resident's current oral
has no difficulty with chewing or swallowing. Resident denies oral pain. Resident states she has no oral sores, refused oral exam. Resident is able to enjoy foods per her choice and says she will not have dentures and does not need teeth to enjoy food. Resident does own oral care per her choice...Will proceed with a care plan...."

No care plan for dental was located.

A Progress note dated 01/17/2017 at 5:50 a.m., indicated Resident 77 had a complaint of left lower mouth pain and stated it felt like it was infected. The left jaw, left side of the face, and left chin area were extremely reddened and swollen. The Medical Doctor (MD) was notified and stated to "refer to a dentist." The resident was informed and stated she did not wish to go out of the facility to see a dentist.

A dental note from the facility's ancillary on site dentistry service dated 01/12/2017, indicated Resident 77 was seen in her room due to the facility reported recent dental discomfort. Patient reported discomfort of the lower left quadrant which was alleviated with Tylenol. An Intra-oral exam revealed many retained, unrestorable root tips in the maxilla, poor oral hygiene and heavy
plaque and calculus throughout mandibular remaining teeth. "... Pt [Patient] pointed to tooth #19: gross debridement recommended prior to fully diagnose caries and existing conditions. Due to quantity of retained roots, pt dental anxiety and underlying general health, recommend referral to offsite dental clinic for full mouth radiographs and likely extraction per pt's request. Pt is very apprehensive to pursue dental care as she has not been to a dentist for many years...."

No follow up progress notes, dental notes, or referral to an offsite dental clinic were located.

During an interview on 06/12/2017 at 10:49 a.m., Resident 77 indicated she had her own teeth with some missing and a few broken teeth which broke off while she was eating her food at the facility and she had told the dentist "she wanted her teeth removed, well at least the broken ones removed." She indicated "having missing front teeth depresses her and embarrasses her because she likes to smile and would love to have teeth to smile again." She indicated she was "a little scared of the dentist but who wouldn't be with someone digging in your mouth."

By what date the systemic changes will be completed:
Compliance Date: 7/13/17
During an interview on 06/12/2017 at 4:05 p.m., the Nursing Consultant indicated the facility should have followed up on Resident 77's wishes to pursue offsite dental care after the dentist seen her at the facility, re-evaluated her pain, set up the appointment and documented in the progress notes.

During an interview on 06/13/2017 at 9:31 a.m., the Social Service Director indicated when the facility dentist sees a resident and would make a note indicating the need for outside services, the Social Services department would address it first by reviewing the note and then would verbally tell the nursing staff so an appointment could have been made.

A current facility policy titled "Dental Services" dated revised 01/2016, received from the Social Service Director on 06/13/2017 at 9:36 a.m., indicated "...The facility will obtain contracted outside dental services to meet the routine and emergency dental needs of each resident...For residents who chose to refuse services, dental service options may be reviewed with the residents as needed...The facility will assist in scheduling and transporting residents to dental appointments as needed. The facility will make referrals to dental services as needed for dental issues or
missing dentures...."

3.1-24(b)

483.45(b)(2)(3)(g)(h)
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Based on observation, interview and record review, the facility failed to dispense of expired medications, ensure residents did not receive expired medications, properly store medications and properly label both over-the-counter and prescription medications in 7 of 7 medication carts reviewed for medication storage (Residents 2, 4, 5, 28, 37, 60, 81, 104, 121, 128, 130, 133, 168, 169, 178, and 180).

Findings include:

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**F431-Drug Records, Label/Store Drugs & Biologicals**

It is the practice of this facility that all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 155121  
**MULTIPLE CONSTRUCTION:** 00  
**WING:**

**DATE SURVEY COMPLETED:** 06/13/2017

**NAME OF PROVIDER OR SUPPLIER:** ROSEWALK VILLAGE AT LAFAYETTE  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1903 UNION ST  
**LAFAYETTE, IN 47904**

### D-Hall Medication Cart:
1. One vial of Humalog (insulin, used in treatment of Diabetes) 100 units/per vial, for Resident 121, was found opened and not dated.
2. One Levemir (insulin detemir, used in the treatment of Diabetes) pen for Resident 133 was found unopened on the medication cart with instructions to refrigerate until opened.

### Auguste's Cottage Cart:
1. A Combivent -Respimat (inhaler) was found opened, undated, with no pharmacy label, no resident name and no instructions for use.

### Moving Forward North Hall Cart:
1. Three tubes of Oragel Baby (teething gel) for Resident 178 were found opened and not dated.
2. A vial of Lumigan 0.01% eye drops (prostaglandin agonist) for Resident 168 was found opened and not dated.

### Moving Forward South Cart:
1. A Breo Ellipta (inhaler) 100 microgram (mcg)/25 mcg was found with no pharmacy label.
2. A Spiriva Respimat 2.5 mcg (inhaler)

### Resident 121 undated Humalog was discarded and a new vial obtained and dated when opened.  
### Resident 133 Levemir pen was discarded and a new insulin pen was obtained and dated when opened.
### Combivent inhaler was discarded and a new one ordered for the resident affected  
### Resident 178 oragel and lumigan was discarded and new medications obtained and dated when opened.
### Breo Ellipta inhaler was discarded and a new one obtained for the resident affected.
### Resident 180 spirva inhaler and Ventolin HFA inhaler was discarded and a new ones obtained and dated when opened.
### Advair Diskus inhaler was discarded and a new one obtained for the affected resident.
### Resident 37 latanoprost eye drops were discarded and new drops obtained and dated when opened.
### Resident 4 brimonidine eye drops were discarded and new drops obtained and dated when opened.
### Resident 28 latanoprost eye drops were discarded and new drops obtained and dated when opened.
### Resident 81 artificial tear eye drops were discarded and new drops obtained and dated when opened.
for Resident 180 was found with no opened date.
3. A Ventolin HFA (inhaler) for Resident 180 was found with no opened date.

Second Floor South Hall Even Cart:
1. A container of Latanoprost 0.005% eye drops (prostaglandin agonist) for Resident 37 was found with an expiration date of 6/10/17. The container was found on 6/12/17.
2. A container of Artificial Tears solution opened.
Resident 2 artificial tear eye drops were discarded and new drops obtained and dated when opened.
Resident 128 natural balance tear eye drops were discarded and new drops obtained and dated when opened.
The 2 advair inhalers, ellipta, Spiriva inhaler with no labels have been discarded and new inhalers obtained for the affected residents.
Resident 130 ketotifen eye drops were discarded and new drops obtained when opened.
Resident 169 Levemir was discarded and a new vial obtained and dated when opened.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:
All residents have the potential to be affected by this finding. A facility wide audit of all medication and treatment carts will be completed on or before 7/6/17 to ensure that all medication have appropriate date opened stickers in place and are within the drug expiration date per manufacturer's recommendations and that all medication is...
for Resident 2 was found to be expired and not removed from the cart.
5. A container of Natural Balance tears was found for Resident 128 with expiration date prior to 6/12/17, unopened but still in the medication cart.

Second Floor East Hall Cart:
1. Two Advair Inhalers were found with no pharmacy label.
2. An Ellipta Inhaler was found with no pharmacy label.
3. A Spiriva Inhaler was found with no pharmacy label.
4. A container of Ketotifen eye drops (an antihistamine) 0.25% solution for Resident 130 was found with no opened date.
5. TMPPolymyxin 10,000 units/1 milligram (antimicrobial for ophthalmic use) for Resident 5 was found with a start date of 6/1/17 and an end date of 6/3/17 still in the medication cart.
6. A tube of Clotrimazol/Bethmethasone Cream 1-0.05% (an antifungal) was found in the cart for Resident 60 with no opened date. The start date was 6/2/17 and a discontinued date of 6/8/17.
7. A vial of Levemir (insulin detemir, used in treatment of Diabetes) for Resident 169 was found with no opened date and no pharmacy label.

During an interview on 6/12/17 at 3:26 PM appropriately labeled with the resident name. Pharmacy technics will also be completing a facility wide audit of all carts on 7/5/17.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
DNS/designee will in-service all Licensed Nurses the facility policy related to Labeling, Storage and Expiration dates of Medications, Biologicals on or before 7/6/17. The DNS/designee will be completing weekly medication cart inspections to ensure all medications are labeled and date open stickers are in place and there are no expired medications.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). DNS/designee will complete the QA tool Medication Storage Review daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
p.m., the Unit Manager (UM 2) indicated she expected the medications should be dated when opened and labeled with a Resident's name and instructions for administration.

A current policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 1/1/13, obtained from the Director of Nursing on 6/12/17 at 4:00 p.m., indicated "...Applicability: This policy sets forth procedures relating to the storage of medications, biologicals, syringes and needles...4. Facility should ensure that medications and biologicals 4.1 Have an expiration date on the label; 4.2 have not been retained longer than recommended by manufacturer or supplier guidelines; or, 4.3 have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological is opened. Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

3.1-25(j)
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Address:**
1903 UNION ST
LAFAYETTE, IN 47904

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**Summary Statement of Deficiencies**

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| 483.80(a)(1)(2)(4)(e)(f) | Infection control, prevent spread, and lINENS | (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### IDENTIFICATION NUMBER:
- **MULTIPLE CONSTRUCTION**
  - A. BUILDING: 00
  - B. WING: __________

#### DATE SURVEY COMPLETED:
- 06/13/2017

#### NAME OF PROVIDER OR SUPPLIER:
- ROSEWALK VILLAGE AT LAFAYETTE

#### STREET ADDRESS, CITY, STATE, ZIP CODE:
- 1903 UNION ST, LAFAYETTE, IN 47904

#### SUMMARY STATEMENT OF DEFICIENCIES

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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<td>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</td>
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<td>(iv) When and how isolation should be used for a resident; including but not limited to:</td>
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<td>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</td>
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<td>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</td>
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<td>(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</td>
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<td>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</td>
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<td>(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.</td>
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<td>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</td>
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<td>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</td>
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Based on interview and record review, the facility failed to ensure infections acquired in the facility were accurately tracked for 1 of 1 resident reviewed for infection control (Resident 114).

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**F441-Infection Control, Prevent Spread, Linens**

It is the practice of this facility to establish and maintain an Infection Control Program designed to provide a safe,
Finding includes:

Resident 114's closed record was reviewed on 6/8/17 at 3:03 p.m. Diagnoses included, but were not limited to, stage I pressure wound, Parkinson's disease and dementia.

A physician's order for Elimite (a cream used to treat scabies) was ordered on 5/10/2017.

On 5/10/2017, Resident 114 was placed on contact isolation.

Review of the "Surveillance Log of Resident Infections" on 6/12/2017 at 11:51 a.m., with the Continuing Education Coordinator (CEC), did not indicate tracking for Resident 114's skin issue which required contact isolation.

Review of the "Healthcare Associated Infection Report" on 6/12/2017 at 11:23 a.m., with the CEC, did not indicate tracking for Resident 114's skin issue which required contact isolation.

During an interview on 6/12/2017 at 11:58 a.m., the CEC indicated she did not see where Resident 114's skin condition requiring contact isolation was documented in the tracking system.

Sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

Residents no longer reside at the facility. Facility Infection Control log for May 2017 has been corrected to reflect the resident's infection while at the facility.

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**

All residents with infections have the potential to be affected by this finding. Any resident with an infection and/or requiring isolation was reviewed by the Nurse Management Team to ensure that all necessary precautions are in place per individualized need. Facility audit of the last 30 days of the Infection Control Surveillance Log was completed to ensure that all residents with potential infections were being tracked.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

DNS/designee will in-service CEC on Infection Control Surveillance Log and daily tracking on or before 7/6/17. DNS/designee will
A current facility policy titled "Infection Prevention and Control Program" reviewed 11/2016, received from the Administrater on 6/13/2017 at 10:00 a.m., indicated "...Goals: The goals of the infection prevention and control program are to.....2. Monitor and identify occurrences of infection and implement appropriate control measures to prevent outbreaks and cross-contamination....4. Maintain records to improve infection control and prevention processes and outcomes. 5. Maintain compliance with state and federal regulations related to infection prevention and control...."

3.1-18(b)(3)

F 0465
SS=D
Bldg. 00

483.90(i)(5)
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT
(i) Other Environmental Conditions

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.

Based on observation and interview, the
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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#### PROXY/CSP/CMS IDENTIFICATION NUMBER:

155121

#### DATE SURVEY COMPLETED

06/13/2017

### NAME OF PROVIDER OR SUPPLIER

ROSEWALK VILLAGE AT LAFAYETTE

### STREET ADDRESS, CITY, STATE, ZIP CODE

1903 UNION ST
LAFAYETTE, IN 47904

### SUMMARY STATEMENT OF DEFICIENCIES

It is the practice of this facility to ensure that the resident's environment remains as free of accident hazards as is possible; and to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

### PROVIDER'S PLAN OF CORRECTION

#### WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

No residents were found to be affected by this finding. The tables in the dining room were immediately cleaned. The top of the dresser in room 207 was immediately dusted. The bathroom faucet in room 225 was immediately fixed.

#### HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN:

All residents have the potential to be affected by this finding. The Maintenance Director/designee will audit all bathroom sinks. The Housekeeping Supervisor/designee will audit rooms for dust accumulation and dining room tables for cleanliness.

#### WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:

1. Six of the thirteen tables in the second floor dining room had food debris and streaks of dried food and dried liquid. Residents were sitting at the tables and were watching television or completing solitary activities.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 155121

A. BUILDING
B. WING

MULTIPLE CONSTRUCTION

DATE SURVEY COMPLETED: 06/13/2017

NAME OF PROVIDER OR SUPPLIER
ROSEWALK VILLAGE AT LAFAYETTE
1903 UNION ST
LAFAYETTE, IN 47904

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG ID

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

2. The top of the dresser in room 207 B was covered with dust.
3. The bathroom faucet in room 225 was loose from the sink base.

During the walk through tour on 6/08/17 at 10:16 a.m., the Housekeeping/Laundry Supervisor indicated the Dietary Department staff should wash the dining tables after meals and also indicated she did not know how the dust on the dresser was missed during the routine room cleaning. The Maintenance Supervisor indicated the faucet was missing a plastic piece from under the sink which would hold the faucet in place and he was not aware of the loose faucet previously. He also indicated staff should fill out a work order for any needed repairs.

The Maintenance Supervisor indicated there was no policy on completing work orders.

3.1-19(f)(5)

Maintenance Supervisor/designee will audit rooms for repairs utilizing a monthly schedule. Housekeeping Supervisor will audit weekly cleaning schedule of rooms and common areas. Housekeeping Supervisor will in-service housekeeping staff on Cleaning Procedures on or before 7/6/17.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool Dignity and Privacy/Environment of Care daily for 4 weeks and weekly for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed:
Compliance Date: 7/13/17
mental, and psychosocial well-being of each resident.

Based on observation, interview and record review, the Administrator failed to ensure smoking residents were screened using a smoking risk assessment and used the appropriate type of electronic cigarette according to the policy for 4 of 4 residents reviewed for accidents (Resident 70, 77, 32 and 75) and failed to follow up on grievances in a timely manner for 4 of 19 grievances reviewed for timeliness (Resident 21, 12, 83 and 31).

Findings include:

1. Resident 70's record was reviewed on 06/09/2017 at 1:20 p.m. Diagnoses included, but were not limited to, muscle weakness, respiratory failure, dementia without behavioral disturbance, schizophrenia, bipolar disorder, anxiety disorder and nicotine dependence.

A Physician's Order dated 12/16/2015, indicated the resident could have an electronic cigarette at bedside.

Resident 70's care plan addressed the problem the resident uses an electronic cigarette. Interventions included, but were not limited to, "...12/17/2015 - IDT [Interdisciplinary Team] to assess...

F490- Effective Administration/Resident Well-Being

It is the practice of this facility to be administered in a manner that uses resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

- Resident 70 has updated smoking assessment completed and been provided with an allowable electronic cigarette.
- Resident 77 has updated smoking assessment completed and been provided with an allowable electronic cigarette.
- Resident 32 has updated smoking assessment completed and been provided with an allowable electronic cigarette.
- Resident 75 has updated smoking assessment completed and been provided with an allowable electronic cigarette.
- Resident 12 grievance was resolved
- Resident 21 grievance was resolved
- Resident 31 grievance was resolved
- Resident 83 grievance was resolved
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
155121

#### Name of Provider or Supplier:
ROSEWALK VILLAGE AT LAFAYETTE

#### Street Address, City, State, Zip Code:
1903 UNION ST  
LAFAYETTE, IN 47904

#### Date Survey Completed:
06/13/2017

#### Summary Statement of Deficiencies

1. Resident's ability to use the electronic cigarette upon admission/quarterly or upon a significant change...."

   No smoking assessments for Resident 70 were located in her record.

   During an interview on 06/09/2017 at 10:11 a.m., the Social Service Director (SSD) indicated smoking risk assessments should be completed on admission, quarterly or with a significant change and Resident 70 had not had an assessment completed on admission or quarterly after admission.

   On 06/12/2017 at 3:35 p.m., with the Administrator in attendance, Resident 70 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.

2. Resident 77's record was reviewed on 06/12/2017 at 10:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, depressive episodes, anxiety disorder, contracture of the right and left knee, chronic pain, muscle spasm, fibromyalgia and insomnia.

#### How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

All residents have the potential to be affected by this finding. All residents that utilize electronic cigarettes have been provided with an allowable device. All residents that utilize electronic cigarettes have been audited to ensure assessments are up to date. An audit will be completed by the ED/designee of all grievances ensure they have been resolved.

#### What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

ED/designee will educate Social Services on Electronic Cigarette Policy on or before 7/6/17. Social Service will complete smoking assessments for any resident utilizing an electronic cigarette upon admission, quarterly, and/or with any significant change. The ED/designee will in-service the Customer Care Representatives on the grievance policy and the timeliness of completely grievances on or before 7/6/17. All outstanding grievances will be reviewed daily in morning meeting.

#### How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance

- ED/designee will monitor the completion of the required smoking assessments by the Social Service Director.
- Customer Care Representatives will be monitored to ensure the completion of the required grievance tracking.
- ED/designee will report any non-compliance to the facility leadership daily in the morning meeting.

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Event ID: 868111  
Facility ID: 000051  
If continuation sheet: Page 105 of 113
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
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<td>A Physician's Order dated 08/31/2016, indicated the resident may use an electronic cigarette.</td>
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<td>program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool Grievance Resolution daily for 4 weeks and weekly for at least 6 months. The Social Service Department will complete the QA tool labeled Smoking Policy weekly for 4 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.</td>
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<td>Resident 77's care plan addressed the problem the resident wishes to use an electronic cigarette. Interventions included, but were not limited to, &quot;...05/06/2013- Assess for safety awareness r/t [related to] smoking an electronic cigarette....&quot;</td>
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<td>By what date the systemic changes will be completed: Compliance Date: 7/13/17</td>
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<td>No smoking assessments for Resident 77 were located.</td>
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<td>During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 77 had not had a smoking risk assessment completed since 12/2014.</td>
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<td>On 06/13/2017 at 8:54 a.m., with the Administrator in attendance, Resident 77 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.</td>
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<td>3. Resident 32's record was reviewed on 06/12/2017 at 2:00 p.m. Diagnoses included, but were not limited to,</td>
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</table>
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING

**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** ROSEWALK VILLAGE AT LAFAYETTE

**Address:** 1903 UNION ST

**City, State, Zip Code:** LAFAYETTE, IN 47904

**ID:** 155121

**Prefix:** 06/13/2017

**Tag:** ROSEWALK VILLAGE AT LAFAYETTE

### Summary Statement of Deficiencies

**Event ID:** 868111  
**Facility ID:** 000051

<table>
<thead>
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<th>(X4) ID</th>
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- **Summary Statement of Deficiencies:**
  
  Malignant neoplasm of an unspecified part of the bronchus or lung, alcohol dependence, personal history of nicotine dependence, asthma, dementia with behavioral disturbance, heart failure, depressive episodes and anxiety disorder.

  A Physician's Order dated 12/31/2015, indicated the resident may have an electronic cigarette due to nicotine anxiety.

  Resident 32's care plan addressed the problem the resident used an electronic cigarette. Interventions included, but were not limited to, "...12/31/2015- IDT to assess resident's ability to use the electronic cigarette upon admission/quarterly or upon a significant change...."

  No smoking assessments for Resident 32 were located.

  On 06/12/2017 at 3:39 p.m., with the Administrator in attendance, Resident 32 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the battery pack needed to turn the liquid into a vapor.
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:
- MULTIPLE CONSTRUCTION
- A. BUILDING 00
- B. WING

### DATE SURVEY COMPLETED
- 06/13/2017

### NAME OF PROVIDER OR SUPPLIER
- ROSEWALK VILLAGE AT LAFAYETTE

### STREET ADDRESS, CITY, STATE, ZIP CODE
- 1903 UNION ST
- LAFAYETTE, IN 47904

### SUMMARY STATEMENT OF DEFICIENCIES

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>155121</td>
<td>06/13/2017</td>
<td>4:11 p.m.</td>
<td>During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 32 had a smoking risk assessment completed on 05/31/2017 for the first time since being admitted to the facility.</td>
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<td>4. Resident 75's record was reviewed on 06/12/2017 at 2:50 p.m. Diagnoses included, but were not limited to, cough, insomnia, depressive episodes, anxiety, obstructive sleep apnea and chronic obstructive pulmonary disease.</td>
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<td>A Physician's Order dated 11/20/2014, indicated the resident may have an electronic cigarette at bedside.</td>
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</table>
| | | | Resident 75's care plan addressed the problem the resident chose to use an electronic cigarette while at the facility. Interventions included, but were not limited to, "...04/15/2013- Do smoking risk assessment...."
| | | | No smoking assessments for Resident 75 were located. |
| | | | On 06/12/2017 at 3:42 p.m., with the Administrator in attendance, Resident 75 was observed to have an electronic cigarette which required the use of a liquid substance to be placed inside a container. The container was placed on top of a cylinder which contained the... |
battery pack needed to turn the liquid into a vapor.

During an interview on 06/12/2017 at 4:11 p.m., the SSD indicated Resident 75 had a smoking risk assessment completed on 05/16/2017 and the last previous assessment was completed 12/17/2014.

During an interview on 06/13/2017 at 8:54 a.m., the Administrator indicated Social Services would be the department to complete the smoking risk assessments initially, quarterly and with a significant change according to the facility policy. He indicated he was not aware the facility policy discussed only using a certain type of electronic cigarettes. He indicated the residents had always used the liquid version of the electronic cigarette.

A current facility policy titled "Electronic Cigarettes" dated 04/2016, received from the Administrator on 06/09/2017 at 12:25 p.m., indicated "...Allowable electronic cigarettes include those that are self contained or use cartridges; those that use liquid nicotine are not permitted...Each resident requesting to use an electronic cigarette must be screened at admission and/or quarterly, or any significant change, by the IDT team...."

5. Resident grievances were reviewed on
<table>
<thead>
<tr>
<th>ID</th>
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<td>6/9/2017 at 2:00 p.m.</td>
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<td>a. Staff received a Concern/Grievance Form for Resident 21 on 1/20/2017. Section II of the form indicated UM 2 spoke with the resident on 1/28/2017, eight days after the grievance was filed.</td>
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<td>b. Staff received a Concern/Grievance Form for Resident 12 filed by a family member on 2/7/2017. Section II of the form indicated staff spoke with the resident's family member on 2/27/2017, 20 days after the grievance was filed.</td>
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<td>c. Staff received a Concern/Grievance Form for Resident 83 on 5/23/2017. Section II of the form indicated UM 1 spoke with the resident on 5/29/2017, 6 days after the grievance was filed. Section III of the form indicated the schedule pertaining to the grievance was not changed until 6/8/2017, 16 days after the grievance was filed.</td>
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<td>d. Staff received a Concern/Grievance Form for Resident 31 on 5/24/2017, regarding his showers not being completed as scheduled. Section II of the form indicated UM 2 spoke with the resident about the grievance on 5/30/2017, 6 days after the grievance was filed. Section III of the form indicated the grievance was brought up during a</td>
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care plan meeting on 6/8/2017. Review of the "Point of Care History" for Resident 31 indicated he received a shower on 5/30/2017, the day UM 2 spoke with the resident, and as of 6/8/2017, Resident 31 had 0 showers in the month of June.

During an interview on 6/12/2017 at 3:24 p.m., the Administrator indicated staff had "72 hours for actions to be taken" regarding resident grievances.

Review of a current policy revised on 11/2016, received from the Administrator on 6/12/2017 at 3:13 p.m. indicated "...Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance Form was received. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and to ensure their satisfaction. Actions taken must be documented...Responses, appropriate plan/resolution to all complaints, and follow up with resident and/or family will be made within 72 hours...."

3.1-13(q)
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 155121  
**Date Survey Completed:** 06/13/2017

**Name of Provider or Supplier:** Rosewalk Village at Lafayette  
**Street Address, City, State, Zip Code:** 1903 Union St, Lafayette, IN 47904

<table>
<thead>
<tr>
<th>ID</th>
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<th>Completion Date</th>
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</table>
| F9999 | SS=D | Bldg. 00 | 3.14 Personnel  
(t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk with tuberculosis.  
This state rule is not met as evidenced by:  
Based on record review and interview, the facility failed to screen a current employee for tuberculosis (TB) with a 2 step Mantoux skin test (a skin test for tuberculosis) for 1 of 5 employees reviewed for annual TB screening (LPN 1 has been given a 2-step skin test). | F9999 |  | 07/13/2017 |

**Observations/Personnel:** It is the practice of this facility to maintain current and accurate personnel records for all employees including annual screening for tuberculosis.

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

LPN 1 has been given a 2-step skin test

**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**

All employees have the potential to be affected by this finding. Facility audit of all employee’s tuberculosis screening will be completed on or before 7/6/17.

**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**

DNS/designee will in-service CEC on employee tuberculosis tracking on or before 7/6/17. The CEC/designee will ensure that all employees including annual screening for tuberculosis.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER:
ROSEWALK VILLAGE AT LAFAYETTE

STREET ADDRESS, CITY, STATE, ZIP CODE:
1903 UNION ST
LAFAYETTE, IN 47904

STATEMENT OF DEFICIENCIES

Finding includes:

During a record review on 6/9/17 at 1:15 p.m., the annual TB testing for LPN 1 for 2016 was not located. The 2017 TB testing was completed on 3/3/17.

During an interview on 6/9/17 at 2:01 p.m., EMP 2 indicated the 2016 TB testing could not be located and she could not verify it had been completed.

During an interview on 6/9/17 2:39 p.m., the Staff Development Coordinator (SDC) indicated she could not locate the 2016 TB testing for LPN 1. She also indicated the 2017 TB skin test should have been a 2-step skin test due to an incomplete 2016 TB skin test.

A current policy titled "Tuberculosis (TB) Screening for Employees", dated 6/2016, received from the SDC on 6/9/17 at 4:00 p.m., indicated "...2. Employee annual/yearly screening is required of all employees...Procedure for Tuberculin Skin Testing (TST)...6. All TSTs are documented in the employee record...."

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). DNS/designee will complete the QA tool Infection Control Review weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.

By what date the systemic changes will be completed: Compliance Date: 7/13/17

employees have up to date screenings completed and that information is logged in the personnel record.