STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	06/14/2018

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 10, 11, 12, 13, and 14, 2018 Facility number: 000117 Provider number: 155210 AIM number: 100266460 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 31 Other: 23 Total: 56 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2018.	F 0000	F 0000 Please accept this Plan of Correction as our credible allegation of compliance for the deficiencies noted in the 2567 for Heritage House of Greensburg. We are alleging compliance by July 13, 2018 and request a paper compliance review if applicable.	
F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12			

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

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview, record review, and observation, the facility failed to ensure adequate monitoring and ongoing assessment of a resident that utilized a self-release safety belt. This deficient practice effected 1 of 16 residents reviewed for restraints. (Residents 31) Findings include: 1. During an interview on 06/11/18 at 11:15 A.M., LPN (Licensed Practical Nurse) 3 indicated Resident 31 was a fall risk. He had a self-releasing safety belt in place that had helped prevent him from falling. Resident 31's clinical record was reviewed on 06/12/18 at 10:36 A.M. A Quarterly MDS (Minimum Date Set) assessment, dated 04/16/18, indicated the resident was severely cognitively impaired and required extensive assistance with all	F 0604	F0604 It is the policy of this facility that all residents have the right to be treated with respect and dignity. There were no other residents affected by this deficient practice. This was an isolated occurrence. Resident 31 has since received an order for a self releasing seat belt dated 6/14/18. Orders were also received for staff to ensure resident can remove belt independently, daily. A care plan has been developed to address the self releasing belt with daily monitoring of the self releasing safety belt. Resident 31 has been able to self-release his belt each time asked to do so. No other residents currently have	07/14/2018

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	ADLs (Activities of Daily Living) including bed mobility, transferring, dressing, and personal hygiene. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and depression. Resident 31 had a functional limitation of range of motion with impairment of one upper extremity. Resident 31's current orders were reviewed on 06/12/18 at 11:00 A.M. The resident did not have an order in place for a safety belt device of any type. There was no documentation that indicated staff were monitoring the use of the safety belt in the TAR (Treatment Administration Record). On 06/13/18 at 09:09 A.M., Resident 31 was observed in his room sitting in his wheelchair. A safety belt was noted to be fastened around his midsection. During an interview, on 06/13/18 at 01:39 P.M., the DON (Director of Nursing) indicated Resident 31 received therapy after his last fall in April, of this year, and the seat belt was a therapy recommendation. The resident was able to release the safety belt without difficulty and it was not considered a restraint. The therapy department never wrote an order for the safety belt and a Care Plan was not developed. Orders for the self-releasing safety belt with daily monitoring of the resident's ability to release the safety belt and a Care Plan related to the use of the safety belt should have been implemented. During an interview, on 06/14/18 at 11:10 A.M., Resident 31 indicated he could remove his safety belt. During an interview, on 06/14/18 at 4:26 P.M., the Administrator indicated the facility did not have a current policy for following therapy orders, they		a self-releasing belt. However, if the therapy department recommends a self-releasing belt, it will be discussed in our weekly therapy meeting. The OTR will be instructed to write the recommendation for the resident and followed up by the therapy manager. The self-releasing seat belt will be care planned and the MD will be placed on the TAR. The nurse will initial daily that the resident is able to self release belt. A policy has been developed to ensure any new therapy recommendations/orders are followed by the interdisciplinary team. The therapist will write discharge orders on any new recommendations; and then, the nursing department will ensure new orders are carried out, by placing on TAR and care planning. The lead therapist will ensure all discharge therapy recommendations/orders are placed in the chart. The lead therapist or designee will monitor daily during therapy rounds to ensure all therapy discharge orders have been written. The new procedures will be monitored by the DON/designee, 2 times weekly for 4 weeks, then monthly for 6 months or until 100% compliance has been reached. The results will be reported at the QAPI committee meetings to ensure ongoing compliance and	

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	just followed the therapy recommendations. 3.1-26(b) 3.1-26(a)		any recommendations will be followed. Therapy staff and nursing staff will be educated on proper procedure and the Therapy Discharge policy (Attachment A) and Therapy Discharge Recommendations (Attachment AA).	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate			

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	its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop a Care Plan in a timely manner related to falls. This deficient practice effected 1 of 16 residents reviewed for Care Plans. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 06/13/18 at 01:03 P.M. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 05/09/18, indicated the resident was severely cognitively impaired. Diagnoses included, but were not limited to, heart failure, hypertension, and non-Alzheimer dementia. The complete Care Plan was provided by the DON (Director of Nursing) on 06/13/18 at 03:25 P.M. The Care Plan indicated an admission date of 02/13/18. An at risk for falls Care Plan was initiated on 03/23/18. A Nursing Fall Investigation dated 02/27/18 at 10:05 P.M., indicated Resident 29 had an unwitnessed fall and neurological checks were initiated with no noted injuries.	F 0656	F0656 Resident 29 has been assessed and there were no adverse effects secondary to the late implementation of the fall care plan. All new residents admitted to the facility and identified as a fall risk will have an admission/fall care plan developed and implemented within seven days of admission to facility. No other residents have been affected by this deficient practice. All residents with the potential for falls have been reviewed, updates were completed. All new admissions to the facility will be reviewed for the potential for falls. Staff will be in-serviced on developing and implementing new fall care plans. The DON/designee will follow-up to ensure that the fall care plans are developed and implemented per	07/14/2018

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	During an interview, on 06/14/18 at 02:07 P.M., the MDS Coordinator indicated they would develop a Care Plan for a resident's diagnoses, skin impairments, types of assistance needed, falls, and at risk for falls. If a resident had a new concern then the facility would Care Plan for it usually within a day or two. Resident 29 should have had a Care Plan prior to 03/23/18 for the fall that occurred on 02/27/18. The current facility policy titled, " COMPREHENSIVE ASSESSMENT AND CARE PLAN POLICY", was provided by the Administrator on 06/14/18 at 04:26 P.M. The policy indicated "...Policy:...will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs...Procedure: Within 7 days of completion of the resident's comprehensive assessment and for newly admitted residents, no later than 21 days after admission, the facility shall develop a person-centered comprehensive care plan for the resident. 3.1-35(a)		facility policy. The DON/designee will follow-up to ensure that the fall care plans are developed and implemented on all new fall risk residents per facility policy. A care plan fall tool (Attachment B) has been created to ensure new admissions with the potential for falls will be care planned within seven days of admission to the facility. Fall care plans will be reviewed after each admission for 4 weeks, then 2 times a month for 2 months, for 6 months, results will be discussed at our quarterly QAPI meetings to ensure ongoing compliance and any recommendations will be followed. The DON will discuss findings at the QAPI committee. Any deficiencies noted will be corrected immediately.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution			

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	was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿ §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on record review and interview, the facility failed to provide restorative services for a resident on a walking program for 1 of 1 residents reviewed for rehabilitation. (Resident 45) Findings include: The Restorative Program orders, dated 06/01/18, for Resident 45 were provided by the Therapy Manager on 06/13/18 at 11:00 A.M. The orders	F 0676	F0676 Resident 45 was not affected by this deficient practice. Resident 45 was offered a walking program; in which, he refused frequently. Resident 45 was discharged from the facility to home on 6/30/2018. All residents have the potential to be affected by this deficient practice. A new system has been	07/14/2018

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	indicated the resident was to ambulate with a rolling walker and stand-by assistance for 100 to 150 feet. This was for the resident to maximize strength, endurance, and functional mobility. The L-hall ADL (Activities of Daily Living) binder was reviewed on 06/13/18 at 10:01 A.M. The binder contained no records indicating Resident 45 was receiving restorative services for walking. The Progress/Nurse's Notes for Resident 45 for the month of June were provided by the DON (Director of Nursing) on 06/13/18 at 02:55 P.M. There was only one note, dated 06/11/18, that indicated the resident had received restorative walking services. The Admission MDS (Minimum Data Set) assessment, dated 05/01/2018, for Resident 45 indicated he was moderately cognitively impaired and had received therapy services. Diagnoses included, but were not limited to, arthritis and hypertension. The resident needed extensive assistance of one physical staff member for walking in his room and locomotion on the unit. He was not steady walking and only able to stabilize with staff assistance. He used a walker and a wheelchair for mobility. During an interview, on 06/13/18 at 09:59 A.M., the DON indicated the restorative documentation was included in the ADL binder. During an interview, on 06/13/18 at 02:37 P.M., the MDS Coordinator indicated the restorative program ordered by therapy for Resident 45 was for ambulation with a rolling walker and stand by assistance for 100 to 150 feet was added to the Care Plan. The CNAs (Certified Nurse Aide) did not have a log to sign to indicate the resident was		put into place to ensure therapy recommendations are followed. The therapy department will screen all current residents restorative programs to ensure the programs remain appropriate or to see if the programs need revised. The Therapy Recommendations Audit Tool (Attachment C) has been developed by the therapy staff to give recommendations for the residents individual needs and care to enhance his or her highest level of independence after therapy. The new therapy recommendation form will be placed in the residents chart under the therapy tab, and a copy will be placed in the CNA ADL book. The therapy recommendations will be written as a physicians order with approval and then will be placed on the TAR for daily documentation and the care plan. Therapy and nursing staff will be in-serviced on the new therapy recommendation form. Nurses will be educated on proper documentation on the TAR to ensure rehab programs are followed and carried out, by signing that the residents are walked per therapy discharge program. The DON/designee will use the therapy recommendation audit tool to monitor the documentation weekly for four weeks, then 2 times monthly for six months,	

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	being assisted with walking as ordered. There might be a nurse's note documenting it had been done. During an interview, on 06/14/18 at 02:02 P.M., the Therapy Manager indicated when a restorative program was put into place it was to be done daily unless otherwise specified. During an interview, on 06/14/18 at 02:05 P.M., the MDS Coordinator indicated she could not provide any documentation to prove Resident 45 received the restorative therapy services as ordered. During an interview, on 06/13/18 at 10:25 A.M., CNA 9 indicated she did not document on Resident 45's walking program. During an interview, on 06/13/18 at 10:53 A.M., the Therapy Manger indicated the resident came from home. His restorative program consisted of range of motion three to five times a week that he could do himself. He had an ambulation with walker program with a certain amount of feet he was to walk with a rolling walker. She would fill out a restorative program form, give it to MDS Coordinator, then the MDS Coordinator would put a log page for restorative services in a book at the nurses station for the CNAs to document that the services were being done or not done. Therapy trains the CNA staff on the walking program. During an interview, on 06/14/2018 at 04:27 P.M., the Administrator indicated they did not have a current policy for therapy orders. The staff were to follow the therapy recommendations. 3.1-37(a)		then quarterly. The results of the audit will be reviewed by the QAPI committee to ensure ongoing compliance and any recommendations made will be followed.	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to follow appropriate food distribution guidelines in the dining room related to food and linen handling for 2 of 3 dining room observations. This deficient practice affected 6 of 17 residents who were provided meals in the Station 2 dining room. (Residents 29, 51, 11 , 26, 40, and 31) Findings include: 1. During an observation of the Station 2 dining room, on 06/10/18 at 05:03 P.M., the following was noted. CNA (Certified Nurse Aide) 6 was standing with her hands folded across her chest, touching	F 0812	F0812 Resident 29, 51, 11, 26, 40, 31 had no adverse effects from this deficient practice. The facility will ensure that food is safely served in accordance with professional standards for food service safety. No other residents were affected by this deficient practice. All residents have the potential to be affected by this practice. CNA's and activity staff that worked on station 2 during survey were re-educated on proper food handling and placing clothing	07/14/2018

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	her arms and her scrub top. She served a tray to Resident 29, sanitized her hands, served a tray to Resident 51, and pulled the bread out of the wax wrapper with her bare hands. She placed it on the wrapper beside the resident's plate, sanitized her hands, served a tray to Resident 11, touched the bread with her bare hands, sitting the bread on the wrapper beside the resident's plate. She served a plate to Resident 26, touched the slice of bread with the back of her left hand to hold it in place, and buttered the bread using her right hand. She then sanitized her hands. During an interview, on 06/14/18 at 02:40 P.M., CNA 8 indicated the staff was trained to not touch the residents' food and how to hold bread, while buttering the bread, without touching the bread with your bare hands. The current facility policy titled, "Proper Handling of Plates, Utensils and Glasses", was provided by the Director of Nursing on 06/14/18 at 03:48 P.M., The policy indicated, "...Do not touch food with your hands..." 2. During an observation of the Station 2 dining room, on 06/14/2018 at 11:13 A.M., the following was noted. Activities Assistant 10 assisted Resident 29 with a clothing protector, touched the resident's clothing and neck, assisted Resident 40 touched her chair with both hands, assisted Resident 31 with a clothing protector, touched his shirt and neck, then returned to Resident 29 to assist them with a clothing protector. No hand hygiene between residents was observed. During an interview, on 06/14/18 at 11:37 A.M., CNA 5 indicated hands were to be washed or hand sanitizer was to be used between residents.		protectors on residents, sanitizing hands between each resident and using barriers such as gloves, napkin or wax wrapper when buttering bread, or handling other food items. All nursing and activity staff will be re-educated on the policy titled, Proper Handling of Plates, Utensils, Glasses, and Food Items (Attachment D). Emphasis will be placed on using hand sanitizer/hand-washing between residents when placing clothing protectors on residents and the use of barriers (ex.: gloves, napkin, or wax paper) when buttering bread or preparing other food item. Hand sanitizer/hand-washing will be emphasized between each resident. The DON/designee will observe staff when passing meal trays and placing clothing protectors on residents to ensure proper hand hygiene is achieved. The DON/designee will also monitor staff to ensure a barrier is used when buttering bread or other food related services, and that hand hygiene is followed. This will be monitored for the next 4 weeks, then monthly times 3 months, then quarterly, using the Hand hygiene/food service tool (Attachment DD). The outcome of the results will be reviewed by the QAPI committee to ensure ongoing complicance and any	

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	3.1-21(i)(3)		recommendations will be followed. Any staff member found to be non-compliant with proper hand hygiene or improper handling of food will be re-educated.	
F 0842 SS=E Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;			

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	155210	A. BUILDING 00 B. WING	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to complete Neurological Assessments for 4 of 16 residents whose records were reviewed. (Residents 29, 5, 21, and 44)	F 0842	F0842 Residents 29, 5, 21, and 44 had no adverse effects from the incomplete neurological	07/14/2018

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	Findings include: 1. The clinical record for Resident 29 was reviewed on 06/13/18 at 01:03 P.M. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 05/09/18, indicated the resident was severely cognitively impaired. Diagnoses included, but were not limited to, heart failure, hypertension, and non-Alzheimer dementia. A Nursing Fall Investigation, dated 02/27/18 at 10:05 P.M., indicated Resident 29 had an unwitnessed fall with no noted injuries and neurological checks were initiated. A Neurological Assessment Flowsheet, dated 02/27/18, lacked documentation for the following dates and times: 03/01/18 at 10:05 A.M., 02:05 P.M., 06:05 P.M., and 10:05 P.M. 03/02/18 at 10:05 A.M. and 02:05 P.M. A Nursing Fall Investigation, dated 04/06/18 at 04:35 A.M., indicated Resident 29 had an unwitnessed fall with no noted injuries and neurological checks were initiated. A Neurological Assessment Flowsheet, dated 04/06/18, lacked documentation for the following dates and times: 04/08/18 at 12:20 P.M. 04/09/18 at 12:20 A.M. and 04:20 A.M. A resident sign out sheet was provided by the DON (Director of Nursing), on 06/14/18 at 03:03 P.M., from the LOA (Leave of Absent) Binder. There was no indication Resident 29 was out of		assessments. All neuro checks on residents 29, 5, 21, and 44 completed were WNL's. All residents have the potential to be affected by this deficient practice. Any resident that experiences an un-witnessed fall and has hit his or her head will be assessed and the neurological check policy will be followed. The DON/designee will be responsible for ensuring that the nurse on duty will complete neuro-check assessments per policy. Should the DON/designee note any lack in documentation, then the nurse responsible during the shift will be re-educated. All nurses will be re-educated on the neuro-check assessment policy. Any resident experiencing an un-witnesses fall or any witnessed fall where the resident is observed hitting his or her head, will have neurological checks completed per facility policy. A neuro-check audit tool (Attachment E) will be utilized by the DON/designee with each fall for four weeks, then 2 times a week for three months, then one times a week for 6 months. The results of the audit will be reviewed by the QAPI committee to ensure ongoing compliance and any recommendations made will be followed.	

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	the building for the above dates and times. There were no progress notes indicating the resident's neurological assessments were completed. 2. The clinical record for Resident 5 was reviewed on 06/13/18 at 10:31 A.M. The most recent Quarterly MDS assessment, dated 05/09/18, indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, non-Alzheimer dementia and seizure disorder. A Nursing Fall Investigation, dated 02/11/18 at 01:00 P.M., indicated Resident 5 had a self-reported fall with no injuries noted and neurological checks were initiated. A Neurological Assessment Flowsheet, dated 02/12/18, lacked documentation for the following dates and times: 02/14/18 at 10:15 A.M., 02:15 P.M., 06:15 P.M., and 10:15 P.M. A Release of Responsibility for Leave of Absence Form had no indication the Resident was out of the building for the above time. There were no progress notes indicating the resident's neurological assessments were completed. 3. The clinical record for Resident 21 was reviewed on 06/12/18 at 10:14 A.M. The most recent Quarterly MDS assessment, dated 03/27/18, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, heart failure, hypertension, and Bipolar Depression.			

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	A Nursing Fall Investigation, dated 01/11/18 at 08:45 A.M., indicated Resident 21 had an unwitnessed fall with a red mark noted along the top back of her head and neurological checks were initiated A Neurological Assessment Flowsheet, dated 01/11/18, lacked documentation for the following dates and times: 01/12/18 at 05:00 P.M. and 09:00 P.M. A resident sign out sheet was provided by the DON, on 06/14/18 at 03:03 P.M., from the LOA Binder. There was no indication Resident 21 was out of the building for the above dates and times. There were no progress notes indicating the resident's neurological assessments were completed. 4. The clinical record for Resident 44 was reviewed on 06/13/18 at 02:14 P.M. The most recent Annual MDS assessment, dated 05/01/18, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, paraplegia, hypertension, neurogenic bladder, and history of urinary tract infections. A Nursing Fall Investigation, dated 01/11/18 at 05:00 A.M., indicated Resident 44 had an unwitnessed fall with an abrasion on the top of his scalp noted and neurological checks were initiated . A Neurological Assessment Flowsheet, dated 01/11/18, lacked documentation for the following dates and times: 01/11/18 at 07:30 A.M.			

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	01/12/18 at 08:00 P.M. There were no resident sign out sheets in the LOA Binder for Resident 44. There was no indication Resident 44 was out of the building for the above dates and times. There were no progress notes indicating the resident's neurological assessments were completed. During an interview, on 06/14/18 at 02:42 P.M., the DON indicated during an unwitnessed fall the nurse would initiate neurological checks, complete an initial fall assessment, notify the physician and family, and then each shift for the next 72 hours the nurse would complete a fall assessment. If there was a blank spot on the neurological assessments then she would hope the nurses did it and forgot to write it down, the resident could have been LOA, but typically the assessments should have been filled in. The current facility policy titled, "Neurological Assessment", was provided by the DON on 06/14/18 at 03:25 P.M., The policy indicated "...Neurological assessments should be completed at the frequency per policy listed below unless otherwise ordered by the physician...every 15 minutes X [times] 4 then; Every 30 minutes X 2 then; Every 1 hour X 2 then; Every 2 hours X 2 then; Every 4 hours X 16..." 3.1-50(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to administer insulin in a sanitary manner. This deficient practice effected 2 of 5 residents reviewed during medication administration. (Residents 52 and 16) Findings include: Medication administration was observed on 06/13/18 at 12:40 P.M. RN 2 prepared insulin for Resident 52. After using hand sanitizer, she removed an opened vial of insulin from a box in the medication cart, she unwrapped the syringe,	F 0880	F0880 Resident 52 and 16 had no adverse effects from the manner in which the insulin was administered. The RN has been re-educated per policy on proper technique on insulin administration. All residents receiving injections have the potential to be affected by this practice. Nurses will be observed for proper administration of insulin during med pass by	07/14/2018

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	drew up the insulin into the syringe, did not clean the top of the open vial before inserting the needle, then took clean gloves and the syringe of insulin into the resident's room. The RN donned gloves and explained the procedure to the resident. The resident pulled up their shirt. The nurse cleaned an area on the resident's abdomen with an alcohol wipe then administered the insulin. The nurse removed her gloves, exited the room, disposed of the insulin syringe, then used hand sanitizer. Medication administration was observed on 06/14/18 at 01:32 P.M. RN 2 prepared insulin for Resident 16. The RN used hand sanitizer, opened the medication cart, and retrieved a box that contained an open vial of insulin. She unwrapped the syringe, drew up the insulin into the syringe without cleaning the top of the open vial. She explained the procedure to the resident, donned gloves, and administered the insulin into the resident's left shoulder after cleansing it with an alcohol wipe. She pulled down the safety cover on the syringe, removed her gloves, and exited the resident's room. During an interview, on 06/14/18 at 03:19 P.M., the DON (Director of Nursing) indicated when administering insulin, if it was a multi-use vial and it was already opened, the top of the vial should have been cleaned with an alcohol wipe prior to inserting the needle into the vial to draw up the insulin. The current, "INJECTIONS, INSULIN", policy, dated "1/12", was provided by the DON on 06/14/18 at 03:48 P.M. The policy indicated, "...PREPARING THE INSULIN...Cleanse rubber top of insulin vial with alcohol wipe..."		using the Medication Administration Procedure audit tool (Attachment F). No other nurses or residents have been identified. Should there be any other evidence that staff fail to comply with the facility policy on insulin injections, they will be immediately re-educated and progressively disciplined. All licensed nurses will be in-serviced on proper medication pass procedure (Attachment FF) with emphasis on insulin injections and proper cleaning of the rubber top of the insulin bottle. The DON/designee will observe licensed nurses over the next four weeks for proper administration of insulin using the Medication Administration Procedure audit tool. Audits will continue to be conducted after the four weeks, monthly for three months, then quarterly thereafter. The results of the audits will be reviewed by the QAPI committee meetings to ensure ongoing compliance and any recommendations will be followed.	

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	3.1-18(a)			