STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	12/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00278585 and IN00279076. Complaint IN00278585 - Substantiated. Federal/state deficiency related to the allegations is cited at F9999. Complaint IN00279076 - Substantiated. Federal/state deficiencies related to the allegations are cited at F656, F689, F777 and F9999. Survey dates: December 26 and 27, 2018 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 5 Medicaid: 100 Other: 13 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on January 4, 2019	F 0000		
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			

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

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

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	this section. Based on interview and record review, the facility failed to ensure a care plan was developed for a resident's use of a gait belt (assistive device used to assist with transfers or ambulation to decrease the chance of falls or falls with injuries), related to possible negative reaction to the gait belt for 1 of 3 residents reviewed for falls with injuries in which a resident had a fall. (Resident B) Findings include: The clinical record of Resident B was reviewed on 12-26-18 at 11:15 a.m. Her diagnoses included, but were not limited to, PBA (psedobulbar affect), anxiety, depression, history of falls, cerebral infarct, vascular dementia with behaviors, diabetes with retinopathy and high blood pressure. Her most recent recent Minimum Data Set (MDS) assessment, dated 7-14-18, indicated she was able to sometimes understand others and sometimes was able to be understood by others, she required extensive assistance of one person for mobility in bed and for transfers from one surface to another, for walking in her room or the corridor of the unit, for toileting needs and did not use an assistive device for mobility. It indicated her balance was not steady, but was able to be stabilized with staff assistance. It indicated she had not had any falls since the most recent MDS assessment period. Review of Resident B's care plans indicated she was at risk for falls, related to daily use of psychotropic medications, frequent wandering, poor safety awareness and diagnosis of dementia with behavioral disturbances, with a goal to not sustain any falls quarterly. This care plan was initiated on 5-10-16 and revised on 11-28-17 and 6-4-18. Interventions to achieve these goals for	F 0656	F 656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN I. Resident B has discharged from this facility. II. Residents residing at the facility were assessed for a possible negative reaction to a gait belt and if warranted an intervention was added to the care plan. III. A systematic change includes residents who require the use of an assistive device used to assist with transfers or ambulation will be assessed for a negative reaction to a gait belt and if negative reaction is found a care plan will be developed. The systematic change will also include negative reactions to gait belts being recorded on the 24-hour report. The 24-hour report will be reviewed daily (Monday-Friday) by the Director of Nurses or an administrative nurse for any changes to gait belt status and need for additional interventions added to the care plan. Assignment sheets will be updated to include gait belt status. Care plan team will review and update care plans for residents who require the use of assistive devices used to assist with transfers or ambulation. All	01/26/2019

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	this concern included, but were not limited to, bed alarm that would not ring into the room, but into the call light system, call light available at all times, encourage the use of a merriwalker [type of assistive device for ambulation], use of a low bed, use of non-skid socks while in bed, monitor the resident for adverse medication reactions and quarter siderails to the bed as an enabler to arise or move about in bed. In an interview with QMA 2 on 12-26-18 at 5:15 a.m., she indicated Resident B was able to ambulate with the assistance of one person. "She would be able to walk fairly steady with help most days, but sometimes she was unsteady even with 1 person assist...She would frequently attempt to get up and walk without assistance; she just didn't seem to understand she needed help. She did have a bed alarm and low bed." In an interview with CNA 3 on 12-27-18 at 8:55 a.m., he indicated he routinely worked with Resident B. He indicated Resident B had a history of getting up during the night and walking down the hall without assistance, but she was not aware of safety concerns. He indicated she used a regular walker for ambulation with assistance of one staff person. He indicated staff would normally provide Resident B "more of supervision or limited assistance and kind of guide her or walk behind her." CNA 3 indicated he was assisting Resident B on the morning of 9-3-18 when she fell. He indicated he helped her sit on side of bed, then placed her walker in front of her and helped her stand up. He specified Resident B required only limited assistance to stand. "Was able to help her stand by putting my arm under her arm. I turned to get her towels and clothes from the head of the bed.		residents found to have a negative reaction to a gait belt will have the care plan revised with proper interventions identified. Training will be provided to all nursing staff for moving, lifting and gait belt use. This training will also include recording negative reactions to gait belt on 24-hour report. Inservice is scheduled for 1/24/2019. IV. Th Director of Nurses and/or designee will audit 100% of residents identified as having a negative reaction to gait belt. The Director of Nurses will continue ongoing audits of 24-hour report to ensure residents identified as having a negative reaction to gait belts are properly addressed. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: January 26, 2019	

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	By the time I turned around, she was already a few feet ahead of me and was in the process of falling. It was not unusual for her to walk on her own, but of course, was not aware of safety concerns. [I] did not use a gait belt with her...Normally, when [I] would get [name of Resident B] up, [she] would be more of supervision or limited assistance and kind of guide her or walk behind her." CNA 3 indicated he did not know how the determination was made of who needs a gait belt and who doesn't. "I don't recall that she [Resident B] was specified for a gait belt. She did have on the assignment sheet to use a walker or the merry walker." In an interview on 12-27-18 at 11:30 a.m., with Physical Therapy Assistant (PTA) 3, she indicated the therapy staff routinely use gait belts with all transfers or ambulation of residents. In a phone interview with 12-27-18 at 12: 10 p.m., with the Director of Nursing (DON), she indicated, the facility staff should probably utilize a gait belt for any resident that needs assistance with walking. In an interview on 12-27-18 at 11:10 a.m., with the Assistant Director of Nursing (ADON), she indicated, "The staff should be using a gait belt with any resident ambulation unless there is a contraindication for its use." In an interview on 12-27-18 at 11:25 a.m., with CNA 5, she indicated the nursing staff does not routinely use a gait belt on some residents. "Therapy makes the decision on who needs a gait belt." In an interview on 12-27-18 at 1:07 p.m., with the MDS Coordinator, she indicated the facility does			

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	not routinely use a gait belt unless therapy specifically calls for that as a assistive device. In an interview on 12-27-18 at 1:07 p.m., with the CNA Instructor, she indicated the facility did not use a gait belt on Resident B, "because she would just freak out with it. She wouldn't even let us put pants on unless they had an elastic waist. So we would just steady her by holding onto the waist band of her pants." She indicated Resident B's most recent therapy notes, from nearly a year ago only, listed her as stand by assistance. In an interview on 12-27-18 at 4:10 p.m., the MDS Coordinator indicated she did not routinely specify the use of a gait belt on a care plan. "But I suppose if that's what I have to do, I will. We did not put anything in Resident B's care plan about her getting kind of freaked out when someone tries to use a gait belt with her." On 12-27-18 at 11:50 a.m., the ADON provided a copy of a policy entitled, "Safe Lifting and Movement of Residents." This policy had a revision date of July, 2017 and was identified as the policy current utilized by the facility. This policy indicated, "In order to protect the safety and well-being of staff and residents and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting shall be eliminate when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include:			

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	Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is cooperative with staff; and The resident's goals for rehabilitation, including restoring or maintaining functional abilities. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices." This Federal tag relates to Complaint IN00279076. 3.1-35(b)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure supervision and assistive devices were utilized for 1 of 3 residents reviewed for falls with injuries in which a resident identified with dementia, poor safety awareness and need for extensive assistance of one person, had the use of supervision, extensive assistance of one person and assistive devices, prior to a fall which resulted in a fractured hip. (Resident B) Findings include: The clinical record of Resident B was reviewed on	F 0689	F 689 FREE OF ACCIDENT HAZARDS/SUPERVISON/DEVICES I. Resident B has discharged from the facility. II. Residents residing at the facility were assessed for the need of an assistive device used to assist with transfers or ambulation. Assignment sheets were updated.	01/26/2019

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	12-26-18 at 11:15 a.m. Her diagnoses included, but were not limited to, PBA (psedobulbar affect), anxiety, depression, history of falls, cerebral infarct, vascular dementia with behaviors, diabetes with retinopathy and high blood pressure. Her most recent recent Minimum Data Set (MDS) assessment, dated 7-14-18, indicated she was able to sometimes understand others and sometimes was able to be understood by others, she required extensive assistance of one person for mobility in bed and for transfers from one surface to another, for walking in her room or the corridor of the unit, for toileting needs and did not use an assistive device for mobility. It indicated her balance was not steady, but was able to be stabilized with staff assistance. It indicated she had not had any falls since the most recent MDS assessment period. Review of Resident B's care plans indicated she was at risk for falls, related to daily use of psychotropic medications, frequent wandering, poor safety awareness and diagnosis of dementia with behavioral disturbances, with a goal to not sustain any falls quarterly. This care plan was initiated on 5-10-16 and revised on 11-28-17 and 6-4-18. Interventions to achieve these goals for this concern included, but were not limited to, bed alarm that would not ring into the room, but into the call light system, call light available at all times, encourage the use of a merriwalker [type of assistive device for ambulation], use of a low bed, use of non-skid socks while in bed, monitor the resident for adverse medication reactions and quarter siderails to the bed as an enabler to arise or move about in bed. In an interview with CNA 3 on 12-27-18 at 8:55 a.m., he indicated he routinely worked with Resident B. He indicated Resident B had a history		III. A systematic change includes residents who require the use of an assistive device used to assist with transfers or ambulation will be identified on the assignment sheet. Assignment sheets will be updated to include gait belt status. Training will be provided to all nursing staff for moving, lifting and gait belt use. Inservice is scheduled for 1/24/2019. IV. The Director of Nurses and/or designee will audit proper transfer techniques by random observation of nurse aides. These audits will be provided at a minimum of 5 per week for 6 months. Any identified concerns from audits will be addressed immediately. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: January 26, 2019	

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	of getting up during the night and walking down the hall without assistance, but she was not aware of safety concerns. He indicated she used a regular walker for ambulation with assistance of one staff person. He indicated staff would normally provide Resident B "more of supervision or limited assistance and kind of guide her or walk behind her." CNA 3 indicated he was assisting Resident B on the morning of 9-3-18 when she fell. He indicated he helped her sit on side of bed, then placed her walker in front of her and helped her stand up. He specified Resident B required only limited assistance to stand. "Was able to help her stand by putting my arm under her arm. I turned to get her towels and clothes from the head of the bed. By the time I turned around, she was already a few feet ahead of me and was in the process of falling. After we put her back in bed, the nurse noticed her leg looked rotated. When got her up, was able to assist her under her arms and she still didn't seem to be in any pain and no crying or even wimpering. Same, even once back in bed. The nurse had another nurse come and take a look at her...I think she had previous falls, not often, but no real injuries like this. She was sent out to the hospital and we found out later that she had broken her hip." In an interview with QMA 2 on 12-26-18 at 5:15 a.m., she indicated Resident B was able to ambulate with the assistance of one person. "She would be able to walk fairly steady with help most days, but sometimes she was unsteady even with 1 person assist...She would frequently attempt to get up and walk without assistance; she just didn't seem to understand she needed help. She did have a bed alarm and low bed."			

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	In an interview on 12-27-18 at 11:30 a.m., with Physical Therapy Assistant (PTA) 3, she indicated the therapy staff routinely use gait belts with all transfers or ambulation of residents. In a phone interview with 12-27-18 at 12: 10 p.m., with the Director of Nursing (DON), she indicated, the facility staff should probably utilize a gait belt for any resident that needs assistance with walking. In an interview on 12-27-18 at 11:10 a.m., with the Assistant Director of Nursing (ADON), she indicated, "The staff should be using a gait belt with any resident ambulation unless there is a contraindication for its use." In an interview on 12-27-18 at 11:25 a.m., with CNA 5, she indicated the nursing staff does not routinely use a gait belt on some residents. "Therapy makes the decision on who needs a gait belt." In an interview on 12-27-18 at 1:07 p.m., with the MDS Coordinator, she indicated the facility does not routinely use a gait belt unless therapy specifically calls for that as a assistive device. In an interview on 12-27-18 at 1:07 p.m., with the CNA Instructor, she indicated the facility did not use a gait belt on Resident B, "because she would just freak out with it. She wouldn't even let us put pants on unless they had an elastic waist. So we would just steady her by holding onto the waist band of her pants." She indicated Resident B's most recent therapy notes, from nearly a year ago only, listed her as stand by assistance. In an interview on 12-27-18 at 4:10 p.m., the MDS Coordinator indicated she did not routinely			

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specify the use of a gait belt on a care plan. "But I suppose if that's what I have to do, I will. We did not put anything in Resident B's care plan about her getting kind of freaked out when someone tries to use a gait belt with her."

On 12-27-18 at 11:50 a.m., the ADON provided a copy of a policy entitled, "Safe Lifting and Movement of Residents." This policy had a revision date of July, 2017 and was identified as the policy current utilized by the facility. This policy indicated, "In order to protect the safety and well-being of staff and residents and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting shall be eliminate when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is cooperative with staff; and The resident's goals for rehabilitation, including restoring or maintaining functional abilities. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices."

This Federal tag relates to Complaint IN00279076.

3.1-45(a)(2)

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F 0777 SS=D Bldg. 00	483.50(b)(2)(i)(ii) Radiology/Diag Srvcs Ordered/Notify Results §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for falls with injuries promptly notified the resident's physician of an addendum to a xray report to reflect a fractured femur. (Resident C) Findings include: In an interview with the Assistant Director of Nursing (ADON) on 12-27-18 at 12:40 p.m., she indicated, "There was an issue with [name of Resident C]'s xrays." She indicated the facility received an initial xray report, which had a fax stamp date of 10-6-18 at 1:54 p.m., indicating no fractures. "Then several hours later, looks like it [an addendum] was faxed on the same day at 4:19 p.m.," which indicated Resident C's right femur had a fracture. "The nurse apparently did not look at it very closely, and just assumed it was a repeat of the earlier fax. A lot of times, the lab or xray department may send repeats of the same reports This was on 10-6-18, a Saturday. On Monday, 10-8-18, [name of the Director of Nursing] wasn't here and I was going through all	F 0777	F 777 RADIOLOGY/DIAG SRVCS ORDERED/NOTIFY RESULTS I. The physician was notified of the results of the X-ray report for Resident C as soon as nursing staff were aware of the fracture. II. Current residents residing at the facility who have X-ray reports for falls with injuries including any addendums to the X-ray have been identified and their charts have been reviewed to ensure prompt notification to the resident's physician. III. A systematic change includes administration contacting contracted X-ray provider and initiating use of a new notification system in which the Administrator, Director of Nursing,	01/26/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	the paperwork on the clipboard from the weekend. Turns out I was the one who found the addendum. Well, we got a hold of the doctor immediately because the addendum showed a femur fracture. So, as a result, we ended up sending in the reportable to the state late, also." Review of a faxed radiology report, dated 10-6-18, with a fax stamp date and time of 10-6-18 at 1:54 p.m., indicated there were no acute fractures or dislocation of the right knee, hip or pelvis. Review of a second faxed radiology report, dated 10-6-18, and entitled, "Addendum Radiology Report," with a fax stamp date and time of 10-6-18 at 4:19 p.m., indicated, "Addendum: There is acute fracture in mid right femoral shaft with modest anterior displacement." This addendum was located at the end of the interpretation of the right knee xray results on page one of the two page report. Review of the facility's incident report, sent to the Indiana State Department of Health on 10-8-18, indicated Resident C had a fall on 10-6-18, and xrays were obtained on the same date. The initial xrays indicated there were no fractures. However, an addendum was sent to the facility several hours later on 10-6-18 that was not correctly reviewed by the nursing staff. The addendum was not properly reviewed until 10-8-18, at which time the physician and resident were notified of the error and care initiated at that time. In an interview with Resident C on 12-27-18 at p.m., she indicated on 10-6-18, she had a fall and had xrays conducted the same date. She indicated on Monday, 10-8-18, the facility informed her the xray had been reviewed and a fracture of her femur was identified.		and Assistant Director of Nursing will receive a text message alert whenever a positive result is received. For each "positive testing result" text received, management will contact charge nurses to identify what positive result has been received. Management will determine, based on positive result, what further action is required. All results received will be promptly notified to the resident's physician. An in-service will be provided by contracted X-ray service on X-ray policies, procedures and ordering and is planned for 1/24/2019. IV. The Director of Nurses and/or designee will audit all X-ray reports for falls with injuries including any addendums to the X-ray to ensure timely notification is made to the to the resident's physician. The Director of Nurses and/or designee will continue ongoing audits of X-ray reports to ensure timely notification is made to the to the resident's physician. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed.	

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	This Federal tag relates to Complaint IN00279076. 3.1-49(j)(2)		Completion Date: January 26, 2019	
F 9999 Bldg. 00	A. 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees that considers references and and convictions in accordance with IC 16-28-13-3. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations in the facility. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures,	F 9999	F 9999 Personnel I. Cook #6 was terminated for allowing an unqualified person in the dietary department to perform work. II. There have been no other instances of unqualified persons working within the facility. HR Manager has checked all current volunteer personnel files to ensure all requirements for volunteering have been met. III. A systematic change includes staff education on reporting unqualified persons working within the facility to management immediately. Policy on unqualified persons working within the facility will be reviewed upon orientation of each new employee/volunteer. Inservice will be held on 1/25/2019 and policy on unqualified persons working in facility will be reviewed with all staff. IV. HR Manager and/or designee will audit all new employee/volunteer HR files to	01/26/2019

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	and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning of employment. (4) Past employment, experience, and education, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents's rights. (10) Date and reason for separation. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be in millimeters of induration with the date given, dated read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually		ensure all guidelines set forth in the Indiana Code 16-28-13-3 are satisfied prior to any person working within the facility. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: January 26, 2019 F 9999 Administration and management I. Indiana State Department of Health Long Term Care Division was notified of reportable incident as soon as Administration was notified that positive result for Resident C was missed. Resident C immediately received proper treatment and therapy to obtain maximum function at this time. II. Current residents residing at the facility with falls resulting in fracture were all reviewed to ensure timely notification of Indiana State Department of Health Long Term Care Division of reportable	

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	thereafter, employees and nonpaid personnel shall be screened for tuberculosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure unqualified persons did not work or function in the role of an employee within in the dietary department. This deficient practice had the potential to adversely affect 126 to 127 residents who received or potentially received foods from the dietary department on multiple dates in September and October, 2018. Findings include: During an interview with the Chief Executive Officer (CEO) and the Human Resources (HR) Manager on 12-26-18 at 8:58 a.m., they indicated in July, 2018, the long term Dietary Manager retired, creating a need for more staff. The CEO indicated Cook 6 applied for a position in the facility's Dietary Department and was hired, effective 8-20-18. The CEO described Cook 6 as a talented chef. The CEO indicated Cook 6 expressed a desire for his spouse to work at the facility from the point of Cook 6's hire date and forward. The CEO indicated he explained to Cook 6 that if his spouse was hired by the facility, they wouldn't be able to work together. "He decided he was going to have his wife just volunteer. He continually tried this. First time, he was counseled and informed it was a terminatable situation. It happened again. It happened 3 times." The HR Manager indicated she did not think Cook 6 took the CEO seriously when he was told this was a terminatable offense. "He didn't seem to understand why bringing in volunteers could be a potentially serious offense and not to follow the		incident. III. A systematic change includes administration contacting contracted X-ray provider and initiating use of a new notification system in which the Administrator, Director of Nursing, and Assistant Director of Nursing will receive a text message alert whenever a positive result is received. For each “positive testing result” text received, management will contact charge nurses to identify what positive result has been received. Management will determine, based on positive result, what further action is required. All results received that require Indiana State Department of Health Long Term Care Division notification will be reported within the required time frames. An in-service will be provided by contracted X-ray service on X-ray policies, procedures and ordering and is planned for 1/24/2019. IV. The Administrator and/or designee will audit all reportable incidents to ensure timely notification is made to the Indiana State Department of Health Long Term Care Division on all reportable incidents. V. The results of these audits will be discussed at the	

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	employment guidelines." In an interview on 12-27-18 at 10:45 a.m., with the HR Manager, she indicated she had explained to Cook 6 "on more than one occasion that anybody, whether a regular employee or a volunteer, has to go through the hiring process to make sure they are eligible for hire. And especially in dietary where there are sanitation concerns...It was just unfortunate that [name of Cook 6] didn't seem to understand what I was telling him. Even after he was counseled initially, he still allowed his wife to come back into the kitchen two more times. His wife did come in to fill out a job application and I spoke with her, but that is only the beginning of the hiring process. I had told her we would need to have her follow up with the activities manager and she never did that. So, she was never actually hired...We just needed to be able to go through the formal process of hiring her either as a paid employee or an unpaid volunteer and find the right placement for her." On 12-27-18 at 11:45 a.m., the HR Manager provided a copy of a timeline of events in regards to Cook 6. The timeline indicated the following: -Cook 6 was hired on 8-20-18 and he informed the HR Manager at this time his wife would be interested in volunteering at the facility. It indicated at this time, Cook 6 was informed his spouse would need to come to the facility and go through the hiring process in order to volunteer or work at the facility. -The hiring process included, but was not limited to, completion of a work application, taking a drug test, having a TB (tuberculosis skin test), have a criminal background check, orientation to company policies and procedures, including Resident's Rights and HIPPA [sic]. -On 9-1-18 and 9-2-18, Cook 6 asked his spouse to		facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: January 26, 2019	

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	come into the facility and help in the dietary department. "She rearranged the freezer, refrigerator, help serve out in the main kitchen and helped with a resident's birthday party in the main dining room." -On 9-6-18, the HR Manager counseled Cook 6 on not allowing his spouse in the dietary department as she was not an employee or volunteer of the facility. -On 9-7-18, Cook 6 brought his spouse into the facility to complete an employment application. The spouse spoke with the Executive Director and HR Manager at this time. -On 9-23-18, Cook 6's spouse was observed rolling silverware in the dietary department. On 9-27-18, the CEO and HR manager met with Cook 6 regarding his spouse working in the kitchen. "[Name of Cook 6] was told that she was not allowed to be in the kitchen working. She must go through the process. It was a liability to the company and violation of state regulations for her to be working. [Name of CEO] told him that the next time she was in the kitchen it would be grounds for termination." -On 10-8-18, Cook 6's spouse was observed visiting in the kitchen with staff and helped clean up the back room. -On 10-9-18, the Executive Director and HR Manager terminated Cook 6 related to "violation of safety practices or negligence that might cause injury or death to self, fellow workers, residents or visitors. Allowing unauthorized people into restricted area after several warnings. [Name of Cook 6] was still within his 90 day probation." On 12-27-18 at 11:45 a.m., the HR Manager provided a partial copy of the facility's Employee's Handbook. This handbook indicated the following information: -All individual's seeking employment with the			

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	facility must complete an employment application. -Prior to employment, the employee will be given a TB test. -The facility does not prohibit the hiring of friends or family members. However, relatives will not be assigned to an area where a relative is a supervisor, unless approved by the CEO. All relatives and friends recommended by an employee must meet the same employment requirements as any other person applying for the same position. -All new hires will take part in a mandatory general orientation of the facility's policies and procedures, as well as to each department's specific policies and procedures in order to achieve quality resident care. Cook 6 signed an acknowledgement of receipt of the Employee Handbook on 8-20-18, indicating he had read, understood and agreed to comply with its policies and procedures. The State tag relates to Complaint IN00278585 B. 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor during the same hours. The responsibilities of the administrator shall include, but are not limited to the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents.			

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This state rule was not met as evidenced by:

Based on interview and record review, the facility failed to notify the Indiana State Department of Health's Long Term Care Division of a resident who had sustained a femur fracture within 24 hours of occurrence, related to nursing staff not acknowledging a faxed report from the radiology department in a prompt manner for 1 of 3 residents reviewed for falls. (Resident C)

Findings include:

In an interview with the Assistant Director of Nursing on 12-27-18 at 12:40 p.m., she indicated, "There was an issue with [name of Resident C]'s xrays." She indicated the facility received an initial xray report, which had a fax stamp date of 10-6-18 at 1:54 p.m., indicating no fractures. "Then several hours later, looks like it [an addendum] was faxed on the same day at 4:19 p.m.," which indicated Resident C's right femur had a fracture. "The nurse apparently did not look at it very closely, and just assumed it was a repeat of the earlier fax. A lot of times, the lab or xray department may send repeats of the same reports This was on 10-6-18, a Saturday. On Monday, [name of the Director of Nursing] wasn't here and I was going through all the paperwork on the clipboard from the weekend. Turns out I was the one who found the addendum. Well, we got a hold of the doctor immediately because the addendum showed a femur fracture. So, as a result, we ended up sending in the reportable to the state late, also."

Review of a faxed radiology report, dated 10-6-18, with a fax stamp date and time of 10-6-18 at 1:54 p.m., indicated there were no acute fractures or

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	dislocation of the right knee, hip or pelvis. Review of a second faxed radiology report, dated 10-6-18, and labeled, "Addendum Radiology Report," with a fax stamp date and time of 10-6-18 at 4:19 p.m., indicated, "Addendum: There is acute fracture in mid right femoral shaft with modest anterior displacement." This addendum was located at the end of the interpretation of the right knee xray results on page one of the two page report. Review of the facility's incident report, sent to the Indiana State Department of Health on 10-8-18, indicated Resident C had a fall on 10-6-18, and xrays were obtained on the same date. The initial xrays indicated there were no fractures. However, an addendum was sent to the facility several hours later on 10-6-18 that was not correctly reviewed by the nursing staff. The addendum was not properly reviewed until 10-8-18, at which time the physician and resident were notified of the error and care initiated at that time. This Federal tag relates to Complaint IN00279076. 3.1-13(g)(1)(D)			