STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a Recertification and State Licensure Survey. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Survey dates: July 10, 11, 12, 13, 14, and 17, 2017 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 7 Medicaid: 73 Other: 10 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/19/17.	F 0000		
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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

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	(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 results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on observation, record review, and interview, the facility failed to ensure the Physician was notified in a timely manner related to the development of a pressure ulcer and medication refusals for 1 of 3 residents reviewed for pressure ulcers and for 1 of 6 residents reviewed for unnecessary medications. (Residents 6 and 96) Findings include: 1. On 7/11/17 at 9:54 a.m., Resident 6 was observed with a white colored bandage to his right elbow area. The record for Resident 6 was reviewed on 7/13/17 at 9:03 a.m. Diagnoses included, but were not limited to, quadriplegia, chronic pain, pressure ulcer left hip stage 4, contracture, and iron deficiency anemia. The Wound Summary Sheet, dated 7/7/17, indicated the resident had a suspected deep tissue injury to his right elbow which measured 4.3 centimeters	F 0157	**F157** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	08/16/2017

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	(cm) x 2.2 cm x unknown. An entry in the Nursing progress notes, dated 7/13/17 at 2:23 p.m., indicated the resident's Physician was notified of the wound to the right elbow that was found on 7/7/17. New orders were received at that time. Interview with the Wound Nurse, on 7/17/17 at 2:35 p.m., indicated that he was told about the wound after he had "punched out" on 7/7/17. He went to the Unit, assessed the wound, and initiated a Wound Summary sheet. After assessing the wound, the Wound Nurse told another Nurse to contact the resident's Physician and to get treatment orders. On 7/11/17, the Wound Nurse indicated the resident's Physician had still not been contacted about the area to the elbow. At that time, the Wound Nurse indicated that he asked a different Nurse to contact the resident's Physician about the area to the elbow. The Wound Nurse indicated that Tuesdays were "heavy wound days" and that he had a hard time getting everything done, that was why he had asked the Nurse to call the Physician. The resident's Physician was notified of the wound to the right elbow on 7/13/17. Interview with the Director of Nursing, on 7/17/17 at 2:00 p.m., indicated the		Resident #6- Physician was notified of delay in obtaining treatment order. No adverse effects were noted. Resident #96- Physician was notified of medication refusals for 7/5, 7/7 and 7/9/17. No new orders were received. **2) How the facility identified other residents:** Medication Administration Records for the month of July will be reviewed and physicians notified as identified. Treatment orders will be reviewed for all residents with a new skin condition or new admissions in the last 30 days to ensure treatment orders were obtained in a timely manner. Physicians will be notified as identified. **3) Measures put into place/**	

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	resident's Physician should have been notified on 7/7/17 about the wound to the right elbow. The "Pressure Ulcer and Skin Condition Assessment Policy", provided by the Nurse Consultant on 7/17/17 at 2:00 p.m., indicated at the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending Physician will be notified. The Director of Nursing will be notified on a daily basis by the use of the 24 hour report and a skin assessment will be initiated. The initial observation of the wound or skin breakdown will also be described in the Nursing progress notes. 2. The record for Resident 96 was reviewed on 7/12/17 at 11:54 a.m. Diagnoses included, but were not limited to, dementia without behaviors, major depressive disorder, high blood pressure, recurrent severe psychotic symptoms, and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 6/22/17, indicated the resident had some modified cognitive impairment. The current plan of care, dated 6/2017, indicated the resident had a history of medication refusal and pocketing medication.		**System changes:** Licensed nurses will be educated regarding physician notification for change in condition, new skin conditions and medication refusals. **4) How the corrective actions will be monitored:** The DON or designee will audit Medication Administration Records at least 3x/week x30 days, then weekly thereafter. The DON or designee will review all newly identified skin concerns 5x/week to ensure physician has been notified and treatment orders obtained. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify	

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	Physician orders on the current 7/2017 Physician Order Summary (POS) indicated: Abilify (an antipsychotic medication) 4 milligrams (mg) daily Aricept (a medication used for dementia) 10 mg Aspirin 81 mg Ferrous Sulfate 325 mg Oyster Shell Calcium/Vitamin D 500-200 mg Protonix (a medication used for reflux disease) for 40 mg Sertraline (an antidepressant medication) 50 mg Memantine (a medication used for dementia) 5 mg Metoprolol Tartrate (a medication used to lower heart rate and blood pressure) 25 mg The Medication Administration Record (MAR) for 7/2017, indicated the resident had refused all of the above the 9:00 a.m., medications on 7/3, 7/4, 7/5, 7/7 and 7/9/17. Nursing notes dated 7/3 and 7/4/17 indicated the resident had refused all a.m., medication and the Physician and POA (Power of Attorney) were notified. There was no other documentation		any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	

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	regarding Physician notification of the refusals on 7/5, 7/7, and 7/9/17. Interview with Nurse Consultant on 7/14/17 at 11:15 a.m., indicated the Physician was not notified of the medication refusals on 7/5, 7/7, and 7/9/17. The current 6/8/15 "Preparation and General Guidelines" policy, provided by the Director of Nursing on 7/17/17 at 2:00 p.m., indicated, "Medication refusal should be reported to the prescriber." 3.1-5(a)(3)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (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. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to residents being referred to as "Feeders" and not covering a Foley	F 0241	**F241** **The facility requests paper compliance for this citation.**	08/16/2017

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	drainage bag for 2 of 2 residents reviewed for dignity. (Residents 71 and 78) Findings include: 1. On 7/10/17 at 11:21 a.m. and 3:10 p.m., Resident 71 was observed in bed. At that time, the resident's Foley drainage bag was full of yellow urine and facing the door and could be seen from the hallway. The drainage bag was not covered in a dignity bag. On 7/11/17 at 3:45 p.m., the resident was observed in bed. At that time, the resident's Foley drainage bag was full of yellow urine and facing the door and could be seen from the hallway. The drainage bag was not covered in a dignity bag. The record for Resident 71 was reviewed on 7/13/17 at 11:43 a.m. Diagnoses included, but were not limited to, congestive heart failure, COPD, pressure ulcer sacral region, colostomy, kidney failure, high blood pressure, and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment, dated 6/2/17, indicated the resident was cognitively intact. The resident had an indwelling		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #71- Catheter drainage bag was emptied and placed in a dignity bag. CNA #2 was educated regarding dignity, including not referring to residents as “feeders”. **2) How the facility identified other residents:**	

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	Foley catheter for urinary output. Interview with the Director of Nursing on 7/14/17 at 2:15 p.m., indicated the Foley drainage bag should have been covered and not have been facing the doorway. 2. On 7/10/17 at 11:43 a.m., CNA 2 was observed in the Maple assisted dining room. The CNA referred to the residents who eat in that dining room as "Feeders". The CNA said the word "Feeders" three times while standing in the dining room. At that time Resident 78 was sitting at the table waiting for lunch to be served. Interview with the Activity Director on 7/14/17 at 9:45 a.m., indicated she heard the CNA say "Feeder" in front of Resident 78. Interview with the Director of Nursing on 7/14/17 at 2:17 p.m., indicated the CNA should not have referred to the residents as "Feeders". 3.1-3(t)		All residents with an indwelling catheter were observed and dignity bags placed as identified. All residents who need assistance with eating that were present in the dining room had the potential to be affected. **3) Measures put into place/ System changes:** Nursing staff will be educated regarding use of dignity bag for catheter drainage bags. This education will also include proper positioning of the drainage bag and tubing to prevent contact with the floor. Staff will be educated regarding resident dignity, including using preferred names when referring to residents. **4) How the corrective actions will be monitored:** DON or designee will observe	

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			catheter positioning and presence of dignity bag during rounds on varied shifts at least 3x/week. Department managers will observe staff interactions with residents to ensure dignity is maintained during rounds at least 5 times per week on varied shifts and locations. The Executive Director will be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	
F 0309 SS=D Bldg. 00	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,			

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	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 comprehensive person-centered care plan, and the residents' goals and preferences. (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, record review, and interview, the facility failed to assess and monitor non pressure related skin conditions related to bruises for 1 of 3 residents reviewed for non pressure related skin conditions. (Resident 61) Finding includes:	F 0309	**F 309** **The facility requests paper compliance for this citation:** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/16/2017

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	On 7/10/17 at 11:48 a.m., Resident 61 was observed sitting in her wheelchair eating lunch. At that time there was a red/purple discoloration noted to the outside of her right hand. The record for Resident 61 was reviewed on 7/12/17 at 9:54 a.m. Diagnoses included, but were not limited to, delusional disorders, major depressive disorder, high blood pressure, atrial fibrillation, Alzheimer disease, and dementia without behaviors. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/17, indicated the resident was not cognitively intact and received an anticoagulant medication for 7 days. The current plan of care, dated 5/2017 indicated the resident was prescribed Xarelto (an anticoagulant medication) and had the potential for abnormal bleeding. Nurses notes dated 7/1-7/10/17 indicated there was no documentation regarding the red and purple bruise to the resident's right hand. Interview with the Assistant Director of Nursing on 7/12/17 at 1:10 p.m., indicated the nurses should be monitoring		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified :** Resident # 61 was assessed for any further bruising or injury with no negative findings. Plan of care reviewed and updated. **1.How the facility identified other residents :** Skin sweep was performed on all residents to ensure there are no undocumented bruises or skin concerns. **1.Measures put into place / Systemic changes :** Nursing staff will be re-educated regarding policy & procedure for skin inspection, reporting and documentation of skin conditions. **1.How the corrective actions will be monitored :**	

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	the resident's skin for bruising or bleeding every day when they were taking anticoagulant medication. . The "Pressure Ulcer and Skin Condition Assessment Policy," provided by the Nurse Consultant on 7/17/17 at 2:00 p.m., indicated at the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending Physician will be notified. The Director of Nursing will be notified on a daily basis by the use of the 24 hour report and a skin assessment will be initiated. The initial observation of the wound or skin breakdown will also be described in the Nursing progress notes. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Care givers were responsible for promptly notifying the charge nurse of skin observations, including: bruises. 3.1-37(a)		The Director of Nursing or designee will observe at least 5 residents per week and review documentation to ensure all skin conditions are assessed, documented and monitored appropriately. Any deficiencies noted will be corrected and addressed with re-education of staff and/or disciplinary action as deemed appropriate. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **1.Date of compliance : 8/16/17**	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES			

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	(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 observation, record review and interview, the facility failed to ensure treatment orders were obtained in a timely manner for a newly developed pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 6) Finding includes: On 7/11/17 at 9:54 a.m., Resident 6 was observed with a white colored bandage to his right elbow area. The record for Resident 6 was reviewed on 7/13/17 at 9:03 a.m. Diagnoses included, but were not limited to, quadriplegia, chronic pain, pressure ulcer left hip stage 4, contracture, and iron	F 0314	**F314** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The*	08/16/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	deficiency anemia. The Wound Summary Sheet, dated 7/7/17, indicated the resident had a suspected deep tissue injury to his right elbow which measured 4.3 centimeters (cm) x 2.2 cm x unknown. Wound measurements, dated 7/11/17, indicated the wound remained a suspected deep tissue injury and measured 4.0 cm x 2.2 cm x unknown. There was no Physician's order for a treatment to the right elbow on 7/7/17, nor was there any documentation completed in the Nursing progress notes. An entry in the Nursing progress notes, dated 7/13/17 at 2:23 p.m., indicated the resident's Physician was notified of the wound to the right elbow that was found on 7/7/17. New orders were received at that time. A Physician's order, dated 7/13/17, indicated the resident was to receive Anasept antimicrobial gel 0.057%-apply to right elbow topically on the day shift every Tuesday and Friday for wound care. Cleanse the right elbow with Anasept wound cleanser, pat dry, apply anasept gel to wound bed, and cover with foam dressing until healed.		*plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #6- Physician was notified of delay in obtaining treatment order. No adverse effects were noted. **2) How the facility identified other residents:** Treatment orders will be reviewed for all residents with a new skin condition or new admissions in the last 30 days to ensure treatment orders were obtained in a timely manner. Physicians will be notified as identified. **3) Measures put into place/ System changes:** Licensed nurses will be educated regarding physician notification for change in condition, new skin	

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	155277	A. BUILDING 00 B. WING	07/17/2017

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	Interview with the Wound Nurse, on 7/17/17 at 2:35 p.m., indicated that he was told about the wound after he had "punched out" on 7/7/17. He went to the Unit, assessed the wound, and initiated a Wound Summary sheet. After assessing the wound, the Wound Nurse told another Nurse to contact the resident's Physician and to get treatment orders. On 7/11/17, the Wound Nurse indicated the resident's Physician had still not been contacted about the area to the elbow. At that time, the Wound Nurse indicated that he asked a different Nurse to contact the resident's Physician about the area to the elbow. The Wound Nurse indicated that Tuesdays were "heavy wound days" and that he had a hard time getting everything done, that was why he had asked the Nurse to call the Physician. The resident's Physician was notified of the wound to the right elbow on 7/13/17. Interview with the Director of Nursing, on 7/17/17 at 2:00 p.m., indicated the resident's Physician should have been notified on 7/7/17 about the wound to the right elbow. The "Pressure Ulcer and Skin Condition Assessment Policy," provided by the Nurse Consultant on 7/17/17 at 2:00 p.m., indicated at the earliest sign of a		conditions and medication refusals. **4) How the corrective actions will be monitored:** The DON or designee will review all newly identified skin concerns 5x/week to ensure physician has been notified and treatment orders obtained. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	

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	pressure injury or other skin problem, the resident, legal representative, and attending Physician will be notified. The Director of Nursing will be notified on a daily basis by the use of the 24 hour report and a skin assessment will be initiated. The initial observation of the wound or skin breakdown will also be described in the Nursing progress notes. 3.1-40(a)(2) 3.1-40(a)(3)			
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's			

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	clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review and interview, the facility failed to ensure foley (urinary) catheter drainage bags were positioned correctly for 1 of 1 residents reviewed for urinary catheters. (Resident 48) Findings include: On 7/11/17, at 8:35 a.m., Resident 48 was observed in his room eating breakfast. The resident's foley catheter drainage bag was on the floor. On 7/12/17, at 1:35 p.m. and 2:50 p.m., the resident was observed in his room sleeping in his recliner. The bottom of the resident's foley catheter drainage bag was resting on the floor. On 7/13/17, at 1:05 p.m., the resident was observed in his room sleeping in his	F 0315	**F315** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	08/16/2017

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	recliner. The bottom of the resident's foley catheter drainage bag was resting on the floor. On 7/17/17, at 8:33 a.m. and 8:48 a.m., the resident was in his room eating breakfast. The resident's foley catheter drainage bag was on the floor. At 9:18 a.m., the resident was being transferred to his wheelchair by therapy staff. The foley catheter drainage bag was on the floor at this time. The record for Resident 48 was reviewed on 7/12/17 at 9:49 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and urinary tract infection. A Physician's order, dated 4/12/17, indicated the resident had a 16 french foley catheter for the diagnosis of neurogenic bladder. Interview with the Director of Nursing, on 7/14/17 at 2:00 p.m., indicated the resident's foley catheter drainage bag should not have been on the floor. The "Urinary Catheter Care" policy, provided by the Administrator on 7/17/17 at 9:44 a.m., indicated urinary drainage bags and tubing should be positioned to prevent either from touching the floor.		**1) Immediate actions taken for those residents identified:** Resident #48- Catheter drainage bag and tubing were repositioned to prevent from touching the floor. **2) How the facility identified other residents:** All residents with indwelling catheters were observed to ensure proper positioning. **3) Measures put into place/ System changes:** Nursing staff will be educated regarding use of dignity bag for catheter drainage bags. This education will also include proper positioning of the drainage bag and tubing to prevent contact with the floor.	

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	3.1-41(a)(2)		**4) How the corrective actions will be monitored:** DON or designee will observe catheter positioning and presence of dignity bag during rounds on varied shifts at least 3x/week. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	
F 0322 SS=D Bldg. 00	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (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-			

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	(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes received the necessary care and treatments related to medication administration for 1 of 1 resident observed during medication pass for PEG-tubes. (Resident 65) Finding includes: During a medication pass observation, on 7/12/17 at 12:00 p.m., LPN 1 was observed preparing a medication for Resident 65. LPN 1 crushed a Baclofen (treats muscle spasms) tablet into a medication cup and added 5 cc (cubic centimeters) of water to the medication cup. The nurse entered the resident's room and donned clean gloves to both hands. She placed the resident's feeding pump on hold and placed a syringe into	F 0322	**F322** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	08/16/2017

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	the PEG-tube and pulled back to check for residual (volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding). She then administered the medication. The nurse did not check for placement by using a stethoscope to auscultate (listen) and no air bolus was given. Record review for Resident 65 was completed on 7/12/17 at 2:21 p.m. Diagnoses included, but were not limited to hypertension, respiratory failure, and muscle spasms. The Quarterly Minimum Data Set (MDS) assessment, completed on 6/1/17, indicated the resident was in a persistent vegetative state. A Care Plan indicated the resident had potential complications related to tube feeding. An intervention included to verify placement prior to administration of anything through the feeding tube. Interview with LPN 1 on 7/12/17 @1:41 p.m., indicated she should have checked for placement by air bolus and listening with stethoscope before she administered the medication. Interview with the Director of Nursing on		**1) Immediate actions taken for those residents identified:** Resident #65- Resident had no adverse effects related to failure to check for placement. LPN #1 was re-educated on procedure for administering medications via PEG tube. **2) How the facility identified other residents:** All residents with a PEG tube have the potential to be affected. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated regarding procedure for administering medications via PEG tube, including checking for placement prior to administering medication.	

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	7/12/17 at 2:25 p.m., indicated the nurse should have checked placement prior to administering the medication by air bolus. A policy titled, "Medication Administration: Gastrostomy Tube" and received as current from the Administrator on 7/12/17, indicated, "...Procedure: 9. Verify G-tube placement via air bolus and aspiration of gastric contents prior to administering flush or medications...." 3.1-44(a)(2)		**4) How the corrective actions will be monitored:** The DON or designee will observe at least 2 nurses per week administer medications via PEG tube on varied shifts. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	
F 0329 SS=J Bldg. 00	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			

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	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 record review and interview, the facility failed to obtain a PT (prothrombin time) and INR (international normalized ratio) (a	F 0329	**F329** **The facility requests paper**	08/16/2017

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	laboratory blood clotting test) for a resident who was receiving Coumadin (a medication that thins blood) as ordered by the Physician which resulted in hospitalization for hemoptysis (coughing/spitting up blood), a critically elevated PT/INR level-Warfarin (Coumadin) toxicity, and anemia for 1 of 6 residents reviewed for unnecessary medications. (Resident 71) The Immediate Jeopardy began on 5/3/17 when the facility failed to obtain laboratory tests as ordered and was identified on 7/13/17. Resident #71 was transferred to the emergency room on 5/7/17 and required hospitalization for stabilization and treatment of a critical PT/INR level. The Administrator was notified of the Immediate Jeopardy at 5:00 P.M. on 7/13/17. The Immediate Jeopardy was removed and corrected on 5/23/17. The correction date was prior to the start of the survey and therefore Past Noncompliance. Finding includes: The record for Resident 71 was reviewed on 7/13/17 at 11:43 a.m. The resident was admitted to the facility on 4/17/17 from an acute		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #71- PT/INR orders and results were reviewed. Physician was aware of missed PT/INR on 5/3/17. **2) How the facility identified other residents:**	

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	care setting. Diagnoses included, but were not limited to, congestive heart failure, COPD, pressure ulcer sacral region, colostomy, kidney failure, high blood pressure, and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment, dated 6/2/17, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 person physical assist for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident had a Stage 4 pressure ulcer. Physician orders, dated 4/18/17, indicated Jantoven 5 milligrams (mg) Warfarin Sodium (blood thinner). The 4/2017 and 5/2017 Medication Administration Records (MAR), indicated the Warfarin was signed out as being administered to the resident 4/18-4/30 and 5/1-5/6/17. Physician orders, dated 4/17/17, indicated a PT/INR to be drawn on 4/18/17 then every 2 weeks. The laboratory results, dated 4/19/17, indicated the PT was 29.6 (normal: 20.2-30.8) and the INR		All residents receiving Coumadin were reviewed to ensure PT/INR levels were ordered and obtained as ordered. **3) Measures put into place/ System changes:** Licensed staff were re-educated regarding input of PT/INR orders, increased PT/INR monitoring for use of antibiotics, ensuring lab requisitions are completed, and follow up of results using PT/INR tracking tool. **4) How the corrective actions will be monitored:** The DON or designee will audit PT/INR orders and results on all residents receiving Coumadin at least 2x/week to ensure appropriate monitoring and follow up are completed.	

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	was 2.63 (normal: 2-3). There were no other PT/INR results in the clinical record for 5/2 or 5/3/17. Physician orders, dated 5/2/17, indicated Clindamycin (an antibiotic - increased bleeding risk when used with Coumadin) was ordered for a wound infection 300 mg every 6 hours times 10 days. The 5/2017 MAR indicated the Clindamycin was signed out as being administered 5/2-5/7/17. Nursing Progress notes, dated 5/7/17 at 10:37 a.m., indicated "Writer spoke with NP (Nurse Practitioner) in regards to resident coughing up what appears to be blood. NP ordered to send resident to ER if resident agrees. POA (name) notified and stated that it was up to her mother if she wanted to go or not. Resident stated that she feels normal and would like to wait and see how she feels after her husband's birthday party this afternoon." Nursing Progress notes, dated 5/7/17 at 1:33 p.m., indicated "Resident attended husband's		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	

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	birthday party on unit. Resident's daughter (name) approached nurse's station and stated her mother was ready to go out to hospital. Resident denies any pain or discomfort. Vitals WNL (within normal limits). Resident does have a cough which is producing reddish sputum that appears to be blood." The ambulance was notified and the resident left for the hospital. There was no documentation on 5/5 or 5/6 the resident was coughing up blood. The hospital history and physical, dated 5/7/17, indicated "...White female presents to the emergency room complaining of coughing up a blood clot. Patient is accompanied by her family members and the report is that since last night patient has been coughing flecks of blood in the expectorated sputum. This morning she coughed up a very large clot of blood. When asked about the quantity of bleeding she said it is 'a lot'. This is new and the patient has not had this problem in the past. The patient is taking her medications as prescribed and this includes Coumadin. No bleeding from any other source."			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

The resident's lab results were obtained in the emergency room on 5/7/17 as follows:
PT > (greater than) 100 seconds, a high value INR > 9.3 a critical value.

The emergency room Physician's impression and plan:

Critically elevated PT/INR Warfarin toxicity
Hemoptysis large volume
Anemia likely of chronic kidney disease and blood loss.
Admit patient in critical condition to the medical unit with telemetry monitoring.
Patient will be reversed for INR with Vitamin K 10 mg immediately.

Interview with the Director of Nursing (DON) on 7/13/17 at 3:00 p.m., indicated the PT/INR was
not obtained on 5/3/17 as ordered by the Physician.

Interview with the DON on 7/13/17 at 4:10 p.m., indicated the nurses had to physically complete a
lab requisition form for the PT/INR after it was ordered. They also must put the order in the computer and complete a section to notify the lab as well. After reviewing the order in the computer, the

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	DON had discovered the nurse had put the PT/INR order in as a "one time" rather than every 2 weeks. The DON indicated lab was also supposed to send the facility the standing lab orders on paper for each month and that information was distributed to all units, however, they were unable to find the standing order sheets from the lab for the month of May 2017. The DON notified the Physician to put a system in place for residents who were receiving antibiotics and anticoagulants (Coumadin) at the same time. The following system was initiated on 5/23/17: a. Residents receiving antibiotic and anticoagulant therapy at the same time were to have a PT/INR drawn two times a week on Mondays and Thursdays. The DON indicated every Monday and Thursday she personally went to every unit to obtain the results to ensure they were completed. b. Residents receiving only anticoagulant therapy were to have a PT/INR drawn every Monday. The DON indicated every Monday, she went to all the units to obtain the lab results and, if they were not obtained by 5:00 p.m., she called the			

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	lab personally. The Past Noncompliance Immediate Jeopardy began on 5/3/17. The Immediate Jeopardy was removed and corrected on 5/23/17 when the facility completed audits of clinical records for all residents on anticoagulation medications, implemented a flow sheet for monitoring residents on anticoagulation therapy including weekly laboratory work, and instituted on-going daily change of condition audits of all residents including those who were on anticoagulation therapy. The correction date was prior to the start of the survey and was therefore Past Noncompliance. 3.1-48(a)(3)			
F 0431 SS=D Bldg. 00	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			

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	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			

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	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, record review, and interview, the facility failed to ensure narcotic medications were stored properly and safely in 1 of 3 medication rooms. (Pines North Medication Room) Finding includes: On 7/13/17 at 2:12 p.m., the Pines North Medication Room was observed with LPN 2. The refrigerator was unlocked and contained an unlocked EDK (Emergency Drug Kit). The EDK contained controlled narcotic medication that included: - Lorazepam (anxiety medication) 2 mg/ml (milligrams/milliliter) injectable vials = 2 vials - Lorazepam 2 mg oral concentrate vials = 2 vials Interview with LPN 2 at the time of the observation, indicated the refrigerator should have been locked because of the narcotics inside. The current and undated Medication Storage, Labeling, and Expiration Dates policy, provided by the Nurse Consultant on 7/14/17 at 9:18 a.m., indicated "After	F 0431	**F 431** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The refrigerator and EDK on Pines North was locked	08/16/2017

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	receiving controlled substances and adding to inventory, Facility should ensure that Schedule II-V controlled substances are immediately placed into a secured storage area (i.e. a safe, self locked cabinet, or locked room, in all cases in accordance with Applicable Law) and locked." 3.1-25(m) 3.1-25(n)		**2) How the facility identified other residents:** No residents were affected but all other narcotics boxes were assessed for being under double lock. **3) Measures put into place/ System changes:** Licensed nurses will be educated regarding the need to keep all narcotics under double lock. **4) How the corrective actions will be monitored:** Director of Nursing/designee will audit narcotic boxes on each unit 2 times a week for 30 days and then weekly for 30 days, then monthly for 30 days.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/2017**	
F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, 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			

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	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; (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 (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.			

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	(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure an infection control program was implemented related to the storage of reusable equipment such as suction tubing, toothbrushes, bedpans, urinals, and urine collection devices for 1 of 1 residents observed for suctioning and on 5 of 6 units throughout the facility. The facility also failed to ensure 2 residents received an annual tuberculin skin test. (Residents 10, 17, 65 and the Elm, Maple, Linden, Pines Rehab and Pines North units) Findings include: 1. On 7/14/17 at 11:38 a.m., LPN 1 was observed suctioning Resident 65. While suctioning the resident, the plastic bag which the suction canister tubing came from, fell onto the floor. When the LPN was done suctioning the resident, she detached the suction catheter from the	F 0441	**F441** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	08/16/2017

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	tubing and discarded the catheter. After discarding the catheter, the LPN placed the suction canister tubing on top of the dresser. She then proceeded to pick up the plastic bag which had been on the floor. At that time, she placed the suction canister tubing inside the plastic bag and placed it on top of the dresser. Record review for Resident 65 was completed on 7/13/17 at 8:40 a.m. The last yearly TB test completed on the resident was recorded on 4/19/16. The record lacked any documentation a yearly TB had been completed on the resident since 4/19/16. Interview with the Director of Nursing on 7/17/17 at 1:15 p.m., indicated a new bag for the canister tubing should have been obtained and the old bag discarded. 2. Record review for Resident 17 was completed on 7/12/17 at 3:47 p.m. The last yearly TB test completed on the resident was recorded on 8/15/15. The record lacked any documentation a yearly TB test had been completed on the resident since 8/15/15. 3. Record review for Resident 10 was completed on 7/13/17 at 8:30 a.m. The last yearly TB test completed on the resident was recorded on 6/6/16. The record lacked any documentation a yearly		**1) Immediate actions taken for those residents identified:** Resident #10- Annual TB was placed on 7/13/17 Resident #17- Annual TB was placed on 7/13/17 Resident #65- Suction equipment and tubing were replaced and placed in a new storage bag. Identified reusable equipment were stored and/or replaced as indicated. **2) How the facility identified other residents:** An audit was completed of all resident TB testing records to identify other residents affected. All residents identified had TB testing scheduled and completed as indicated. Rounds were completed on all units to ensure reusable equipment were stored appropriately.	

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	TB test had been completed on the resident since 6/6/16. Interview with the Director of Nursing on 7/13/17 at 1:52 p.m., indicated she could not find any documentation the above residents had a TB test completed since the last TB tests recorded in their records. The current and undated "Tuberculosis Exposure Control Plan" policy, provided by the Nurse Consultant on 7/14/17 at 9:12 a.m., indicated "Residents who have significant reactions to the tuberculin test shall be retested annually using the Mantoux method."4. On 7/17/17 at 2:00 p.m., during the Environmental Tour with the Maintenance Supervisor and the Housekeeping Supervisor the following was observed: Pines North a. Room 20, there was a urinal with no lid hanging from the grab bar in the bathroom uncovered. Three residents shared the bathroom. Pines Rehab a. Room 40, there was a urinal on the floor at the bedside. One resident resided in the room.		**3) Measures put into place/ System changes:** Nursing staff will be re-educated regarding proper storage of reusable equipment, including toothbrushes, bedpans, urinals, urine collection devices, and respiratory/suction equipment. Licensed nurses will be educated regarding requirement for TB testing to be completed on admission and annually. **4) How the corrective actions will be monitored:** The DON or designee will audit the TB report on a monthly basis. New admission TB results will be reviewed weekly until first and second step results are completed. Department managers will observe resident rooms on all units during rounds to ensure reusable equipment is stored appropriately at least 3x/week on	

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	Elm a. Room 215, there were 2 toothbrushes laying flat on the edge of the bathroom sink. There were also clothes stored on the bathroom floor in the corner by the door. Two residents shared the bathroom. Maple a. Room 256, there was a urine collection container stored on the floor in the shower. Two residents shared the bathroom. b. Room 257, there was a urine collection container stored on the floor in the shower. Two residents shared the bathroom. Linden a. Room 275, there were pink and yellow wash basins stored on the top shelf of the closet uncovered. Two residents shared the room. Interview with the Maintenance Supervisor and the Housekeeping Supervisor at the time, indicated the above items were improperly stored. 3.1-18(b)(1)		varied shifts. The Executive Director will be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	

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F 0465 SS=E Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (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 facility failed to maintain a functional and sanitary environment related to scuffed, marred and gouged walls, doors, and frames; peeling wood, wall paper and paint; dirty floors, walls, cove bases, ceiling vents and carpet; marred heat registers; cracked floor tiles and plaster; displaced filters; and dried brown substances on walls, toilet seats and floor tiles for 1 of 1 Kitchen, 2 of 4 dining rooms, and 4 of 5 units. (The Main Kitchen, The Timber Assisted Dining Room, The Linden Dining Room, and The Pines North, Elm, Maple, and Linden units.) Findings include: 1. On 7/17/17 at 2:00 p.m., during the Environmental Tour with the	F 0465	**F465** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	08/16/2017

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	Maintenance Supervisor and the Housekeeping Supervisor the following was observed: Pines North Unit a. Room 1, the floor tile was dusty and dirty. The inside of bathroom door was scratched and marred. Three residents resided in the room. Three residents shared the bathroom. b. Room 2, the floor tile throughout the room was dusty and dirty. There were paper clippings on the floor next to the left side of the bed. The bathroom door and door frame were scratched and marred. The heat register in bathroom had chipped paint. Three residents resided in the room. Three residents shred the bathroom. c. Room 3, the floor tile in entry way of the bathroom was dark and discolored. The heat register in bathroom was scuffed and marred. Four residents shared the bathroom. d. Room 4, the curtain rod above the window was loose. Two residents resided in the room. e. Room 6, the floor tile in the bathroom was stained with a dark brown substance.		*federal and state law.* **1) Immediate actions taken for those areas identified:** Pines North Unit Room #1: Floor tile was cleaned of dust and dirt. Inside of the bathroom door scratched and marred area was touched up. Room #2: Floor tile was cleaned of dust, dirt and paper clippings. Bathroom door and door frame scratched and marred area was touched up. Room #3: Floor tile was stripped and re-waxed. Heat register in the bathroom scuffed and marred area was touched up. Room #4: Curtain rod above the window was tightened. Room #8: Marred areas of the bathroom walls and bathroom	

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	The walls in bathroom were scuffed and marred. There was cracked plaster next to the toilet. There was a dried brown substance on the toilet seat. The door to bathroom was scratched and marred. Two residents shared the bathroom. f. Room 8, the bathroom walls were marred. The inside of the bathroom door and frame were marred. Two residents shared the bathroom. g. Room 17, the floor tile in the bathroom was discolored along the cove bases. The bathroom walls and heat register were marred. Four residents shared the bathroom. h. Room 18, there was an accumulation of dust and dirt along the cove bases by entrance to the room. The inside of the bathroom door was scratched and marred. There was an accumulation of dust and dirt along cove bases in the bathroom. One resident resided in the room. Three residents shared the bathroom. bathroom i. Room 20, the inside of the bathroom door was scratched and marred. There was an accumulation of dust and dirt along the cove bases in the bathroom. Three residents shared the bathroom. j. There was an accumulation of lime		door and frame were touched up. Room #17: Floor tiles and coves of the bathroom floor were stripped and re-waxed. Bathroom walls and heat register marred area was touched up . Room #18: Dust and dirt along the cove bases of the entrance and bathroom were cleaned. The marred and scratched area of the inside bathroom door was touched up. Room #20: Marred and scratched area on the inside of the bathroom door was touched up. Dust and dirt along the bases of the bathroom coves was cleaned. Accumulation of lime and calcium build up on the hallway water fountain was cleaned. Elm Unit Room #206: Bathroom was deep cleaned and free of any urine odor. Chipped paint and plaster	

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	and calcium build up on the hallway water fountain. Elm Unit a. Room 206, there was a strong urine odor in the bathroom. There was chipped paint and plaster on the corners of the walls in the bedroom. There was chipped paint behind the head of bed 1. There were two stained ceiling tiles. Two residents shared the bathroom. Two residents resided in the room. b. Room 209, there was a strong urine odor in the bathroom. There was chipped paint and plaster on the corners of the walls in the bedroom. Two residents shared the bathroom. Two residents resided in the room. c. Room 215, there was a dried brown substance on the walls near bed 1. There was torn wall paper. The bedroom floor was sticky. Two residents shared the room. Maple Unit a. Room 256, there was chipped paint and plaster on the corners of the walls in the bedroom. The inside of the bathroom door was scratched and marred. Two		on the corners of the walls in the bedroom were repaired. Chipped paint behind the head of the bed was repaired. Both stained ceiling tile were replaced. Room #209: Bathroom was deep cleaned and free of urine odor. Chipped paint and plaster on the corners of the walls in the bedroom were repaired. Room #215: Dried brown substance on the walls near bed 1 was cleaned. Torn wall paper was touched up. Bedroom floor was cleaned and free of stickiness. Maple Unit Room #256: Chipped paint and plaster on the corners of the walls in the bedroom were repaired. Marred and scratched area of the inside of the bathroom door was touched up. Room #259: Scratched and marred area on the inside of the bathroom door was touched up.	

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	residents resided in the room. Two residents shared the bathroom. b. Room 259, the inside of the bathroom door was scratched and marred. Two residents shared the bathroom. c. Room 262, the inside of the bathroom door was scratched and marred. One residents occupied the bathroom. Linden Unit a. Room 269, there was a strong urine odor in the bathroom. One resident occupied the bathroom. b. Room 273, there was chipped paint and plaster on the corners of the walls in the bedroom. The wood on the bathroom door was peeling. There wall paper was gouged and peeling from the wall behind the chair. There was gouged and chipped paint behind the head of bed 1. The filter in the air conditioner was displaced underneath the unit. Two residents resided in the room. Two residents shared the bathroom. c. Room 275, the filter in the air conditioner was displaced underneath the unit. Two residents resided in the room. Linden Dining Room		Room #262: Scratched and marred area on the inside of the bathroom door was touched up Linden Unit: Room #269: Room was cleaned and free of strong urine order Room #273: Chipped paint and plaster on the corners of the walls in the bedroom were repaired. Wood peeling on the bathroom door was repaired. Gouged and peeling wallpaper behind the chair was repaired. Gouged and chipped paint behind the head of the bed was touched up. The displaced air filter of the air conditioner unit was removed. Room #275: The displaced filter in the air conditioner was removed. Linden Dining Room Dining room floors and walls were	

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	a. The dining room floors and walls were dirty. There was peeling paint on the bases of the tables. Timber Assisted Dining Room a. The carpet was stained and dirty. There was peeling paint on the bases of the tables. 2. During the initial tour of the Kitchen on 7/10/17 at 8:55 a.m., with the Dietary Manager (DM), the following was observed. Kitchen: a. The floors along the baseboards, behind, and under the ovens had a build up of dirt and debris. b. The cold air return vent on the wall next to the window and back door had a build up of dirt and debris. c. The cold air return vent on the wall on the other side of the window had a build of of dirt and debris and was separated from the wall on the bottom which left a large long hole in the wall. d. There were tiles that had separated from the wall next to the walk in		deep cleaned and free of dirt. Peeling paint on the basis of the tables was repainted. Timber Assisted Dining Room The carpet was deep cleaned and free of stain and dirt. Peeling paint on the basis the tables was repainted Kitchen 1.Floors along the baseboards, behind and under the ovens were cleaned and free of dirt and debris 2.Cold air return vent on the wall next to the window and back door were cleaned and free of dirt and debris 3.Cold air return on the other side of the window was cleaned and free of dirt and debris. Modification was completed to repair the large long hole in the wall under the cold air return. 4.Tiles separated from the wall next to the walk in refrigerator were repaired. 5.Cracked and missing tile in the dishwasher room were repaired.	

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	refrigerator. e. There were cracked and missing tiles from the wall in the dishwasher room. Interview with the DM during the tour, indicated the floors were to be swept and mopped daily and should be deep cleaned monthly. She was unaware about the space between the cold air vent and wall and the cracked and missing tiles. The floors, vents, and tiles were in need of repair and or cleaning. 3.1-19(f)		**2) How the facility identified other residents:** All residents have the potential to be affected An audit of resident rooms and common areas was completed. Identified similar concerns noted in the audit based on the findings of the survey have been scheduled for corrections. **3) Measures put into place/ System changes:** Staff was re-in serviced on the importance of completing a maintenance request form when they observe any damage/repairs	

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			needed so they can be tracked for completion. Maintenance/Housekeeping will maintain logs of work order repairs and review them weekly with the Administrator or designee. A minimum of 5 resident rooms including common areas will be inspected per week to identify any repairs/cleaning that need to be completed Maintenance Director or Designee will be responsible for the oversight of these audits. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify	

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			any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not limited to, the following: (1) Residents' rights. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment...The facility must assure the following: (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,	F 9999	**F9999** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	08/16/2017

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	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 of infection with tuberculosis. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete, related to annual TB (tuberculosis) testing and resident rights, abuse and dementia training for 4 of 10 employee files reviewed. (CNA 1, LPN 3, Laundry Aide 1, and Housekeeping Aide 1)		*federal and state law.* **1) Immediate actions taken for those areas identified:** 1.CNA#:1 annual in-services for Resident Rights, Dementia and abuse were completed. 1.LPN#3: Annual TB test and in-services for Resident Rights, Dementia and abuse were completed. 2.Laundry Aide#1: Annual in-services for Resident Rights, Dementia and abuse were completed. 3.Housekeeping Aide#1: Annual TB test and in-services for Resident Rights, Dementia and abuse were completed **2) How the facility identified other residents:** All residents have the potential to be affected	

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	Findings include: Employee files were reviewed on 7/13/17 at 11:00 a.m., and the following were not included in the Personnel File: 1, CNA 1 (hired 9/2/15): 2016 annual inservices for Resident Rights, Dementia and Abuse were not completed. 2. LPN 3 (hired 10/1/14): Annual TB test and inservices for Resident Rights, Dementia and Abuse were not completed for 2016. 3. Laundry Aide 1 (hired 1/18/14): 2016 annual inservices for Resident Rights, Dementia and Abuse were not completed. 4. Housekeeping Aide 1 (hired 9/10/14): Annual TB test and inservices for Resident Rights, Dementia and Abuse were not completed for 2016. Interview with the Human Resources Director on 7/13/17 at 1:03 p.m., indicated she was unable to find documentation the above staff had the required yearly TB testing and inservices completed for the calendar year 2016. The current and undated "Tuberculosis Exposure Control Plan" policy, provided by the Nurse Consultant on 7/14/17 at		An audit of employee files was completed by HR or designee to identify similar concerns based on the findings of the survey and have been scheduled for corrections. **3) Measures put into place/ System changes:** Department heads and Staff were re-in serviced on the importance of completing Annual TB test/screening and in-services for Resident Rights, Dementia and abuse. HR or Designee will ensure that all current employees are brought up to compliance regarding Annual TB test/screening and in-services for Resident Rights, Dementia and abuse by 8/16/2017. A minimum of 5 employee files will be audited weekly to ensure completion of Annual TB test/screening and in-services for Resident Rights, Dementia and	

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	9:12 a.m., indicated "All employees will be screened annually either by PPD skin test, if non-reactor, or TB screening questionnaire, if historically a positive reactor, and symptom free." The current and undated "Required In-servicing" policy, provided by the Nurse Consultant on 7/14/17 at 9:18 a.m., indicated all employees of the healthcare facility will receive in-servicing upon hire and annually as indicated by the state and federal guidelines, includes abuse and neglect, and resident rights. Employees must complete 3 hours of dementia training annually. 3.1-14(k) 3.1-14(k)(1) 3.1-14(t) 3.1-14(t)(1) 3.1-14(u)		abuse. HR or Designee will be responsible for the oversight of these audits. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/16/17**	