STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155409		02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00221289. Complaint IN00221289 - Unsubstantiated due to lack of evidence. Survey dates: February 7, 8, 9, 10, 13, 14 & 15, 2017. Facility number: 000537 Provider number: 155409 AIM number: 100267270 Census bed type: SNF/NF: 49 Total: 49 Census payor type: Medicare: 6 Medicaid: 41 Other: 2 Total: 49 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **The facility respectfully requests paper compliance for these citations.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	22, 2017.			
F 0242 SS=D Bldg. 00	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.			
	Based on interview and record review, the facility failed to ensure a resident was getting up in the morning according to his preference time (7:30 a.m.), for 1 of 1 resident reviewed for choices. (Resident #24) Findings include: On 2/09/2017 at 9:00 a.m., the clinical record of Resident #24 was reviewed. Diagnosis included but not limited to Non-Alzheimer's dementia.	F 0242	It is the policy of the facility to ensure that residents exercise their rights to choose activities (to include sleeping, waking and bathing times) as well as other health care services consistent with their interests, assessment findings and plan of care. Resident #24 gets up in the morning at a time that is agreeable and according to the preference of the resident as stated by the	03/17/2017

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	Minimum Data Set Assessment, quarterly review dated 11/01/2016, indicated Resident #24's cognitive skills for Daily Decision Making were severely impaired - "never/rarely made decisions." Transfer - how resident moves between surfaces including to or from; bed, chair, wheelchair, standing position. Resident was coded as total dependence and required two person, physical assist, with all transfers from bed to wheelchair. Care Plan for Resident #24, dated 10/23/14, indicated Focus: Resident #24 is unable to inform staff of their preference. Goal: All of the Resident's needs will be met by staff daily through next review, target date: 2/15/17. Interventions included, but not limited to: Attempt to find out resident's preference from family, friends, responsible party, and or guardian. On 2/07/2017 at 1:08 p.m., during an interview with Resident #24's guardian, the guardian indicated the staff wake the resident up at 4:00 a.m. every morning and get him ready for the day. The resident's guardian also indicated she had asked several Certified Nursing Assistants not to get him up that early in the morning. "The staff continue to get him up at 4:00 a.m."		resident's guardian. Residents who reside in the facility have the potential to be affected by this finding. Interviews were conducted facility wide to verify the residents' choices/preferences related to personal care and services. Non-interviewable residents had their responsible party contacted and interviewed as to the resident's choices and preferences. These verified preferences were documented and care planned. CNA assignment information was updated as indicated. New admissions will have their preferences defined and shared with the facility as part of the admission process so that these preferences can be honored. The DON/ADON or SSD will interview 10 residents (or their responsible parties if they are not interviewable) 3 days weekly on various shifts and to include some weekend days to see that	

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	On 2/07/2017 at 2:00 p.m., during an interview with the Director of Nursing (DON), the DON indicated they do not get Resident #24 up at 4:00 a.m., "It's usually around 5:30 a.m." On 2/08/2017 at 9:30 a.m., during an interview with Resident #24's guardian, the guardian indicated based on past preference the resident would prefer to get up around 7:30 a.m. The facility serves breakfast at 8:00 a.m. On 2/15/2017 at 1:43 p.m., the Administrator provided a Policy undated, and indicated it was the current policy being used by the facility, titled: Conduct between staff and Residents---Dignity based. "Policy: It is the policy of the facility to ensure that conduct between the staff and the residents promotes growth, development and as much independence as possible for each individual resident while maintaining safety and comfort and security for the resident. Further, the resident will have their choices and preferences honored as much as possible within the facility to include but not be limited to choice of: ....b. Time to get up for the day. ...H. Specific request or preferences made on an individual basis."		preferences are being honored. Any concerns will be addressed and corrected as found. Further, as care plan reviews are done the preferences will be reviewed and updated as indicated and as stated by the IDT (Interdisciplinary Team) based on the stated desires of the resident and/or their responsible party. The monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will take place at least 1 day weekly at which time 10 residents (or their responsible parties if they are not interviewable) will be interviewed to see that preferences are being honored. This monitoring will continue for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will continue ongoing. Note: Preferences will be reviewed during care plan meetings ongoing as part of	

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	3.1-3(u)(1)		the care planning process. Input from the resident and/or the resident's responsible party as well as observations of and discussion with the IDT will aid in defining the resident's preferences which will be care planned and honored. At an in-service held 3/1/2017, for all staff the following was reviewed: A.) Resident Rights—Choices/Preferences (related to care and services) B.) Dignity C.) Customer Service D.) Documentation/Care Planning/CNA assignment information E.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring by the DON/ADON or SSD will be reviewed. Any	

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			concerns will have been addressed as discovered. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plans will be monitored weekly by the Administrator until resolution.	
F 0248 SS=D Bldg. 00	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure activities were provided to meet the interests of residents, and residents were escorted and encouraged to attend activities, or provided 1:1 activity programs, based on their assessed preferences, for 2 of 4 residents reviewed for activities. (Residents #51 and #21)	F 0248	It is the policy of the facility to ensure that activities are coordinated and care planned and provided for each resident to meet their interests and their needs. Further, the facility sees that residents are escorted or assisted as needed to appropriate and desired	03/17/2017

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	Findings include: 1. The clinical record of Resident #51 was reviewed on 2/10/17 at 10:47 a.m. Diagnoses for the resident included, but were not limited to, major depressive disorder, anxiety disorder, and heart disease. An admission Minimum Data Set assessment, dated 1/22/17, indicated Resident #51 was independent in his ability to make decisions. During an interview on 2/8/17 at 2:14 p.m., Resident #51 indicated there were not enough activities to interest him. He indicated, "I'm really not into making paper houses and cutting out pictures of flowers." He would like more movies, "but not Elvis Presley movies." There wasn't, "anything to do around here in the evenings and on the weekends except watch TV." An Activity Admission Review, dated 1/11/17, indicated Resident #51's interests were art projects, computers, video games, spiritual programs, outings, pet interactions, keeping up with the news, card games, music, social parties, talking, old sitcoms, movies with action and drama.		activities which residents are encouraged to attend. Residents who require 1:1 activities based on assessment, are offered these same opportunities and assistance. Resident #51 and Resident #21 have been reassessed and evaluated for preferred activities and these activities are care planned and executed for these residents. Resident #21 has 1:1 activities care planned. Resident #21 is assisted to activities as needed. Additionally, there are facility activities planned in the evenings to include Saturday and Sunday evening. Residents who reside in the facility have the potential to be affected by this finding. Residents were reassessed as to their interests and preferences related to activities. Non-interviewable residents had input gathered from family and/or their	

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	Review of an Activity Schedule for January, 2017, indicated, of 143 events scheduled, 9 were in the evening. There were no Saturday or Sunday evening events scheduled. Review of Resident #51's Activity Log for January, 2017, indicated he attended 16 of a possible 143 activity events, including current events, Let It Out, celebrity birthdays, bingo and euchre. Review of an Activity Schedule for February, 2017, indicated, of 180 events scheduled, 8 were in the evening. There were no Saturday or Sunday evening events scheduled, except for 1 activity at 6:00 p.m. on 2/5/17 for the Superbowl (television). Review of a February, 2017 Activity Log (2/1/17 - 2/9/17) for the resident indicated he attended 14 of the 59 activity events scheduled, including current events, today's history, bingo, Super Bowl, euchre, and fun with food. On 2/14/17 at 4:00 p.m., the Activity Director indicated he only has 1 activity assistant, 2 days per week, no one to provide activities on a regular basis in the evenings during the week and on the weekend evenings.		responsible party. The Activity Calendar has been revised to include activities of interest based on resident preferences and interviews. Further, individual care plans have been revised and updated to include any new activity preferences. The 1:1 Activity Program has been revised to include residents who, per assessment, would benefit from that type of programming. These residents have had activities planned to meet their preferences and needs. New admissions will have their activity preferences defined and shared with the staff as part of the admission process so that their activity needs can be care planned and met. The Administrator/Designee will monitor 10 residents 3 days weekly on various shifts and to include some weekend days to ensure that the residents are content with their personal Activity Program. Non-interviewable residents	

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	2. Observation of Resident #21 on 02/13/2017 indicated the following: a. 09:00 a.m., in resident's room, setting in wheelchair, asleep with television (TV) on. b. 10:00 a.m., in resident's room, setting in wheelchair, asleep with TV on. c. 11:30 a.m., in assist dining room, in wheelchair, asleep, no activities. d. 12:20 p.m., in assist dining room, in wheelchair, asleep, no activities. Observation on 02/13/2017 at 10:30 a.m. of activity program titled "Current Events" lead by the Activity Director, identified Resident #21 was not present. Resident #21 was observed in their room, in wheelchair, asleep with TV on. Observation on 02/13/2017 at 2:05 p.m. of activity program titled "Music and UNO" lead by the Activity Director, identified Resident #21 as not present. Resident #21, was observed in their room, in bed, asleep. Observation of Resident #21 on 02/14/2017 indicated the following: a. 09:00 a.m., in resident's room, setting in wheelchair, asleep with television (TV) on. b. 10:00 a.m., in resident's room, setting in wheelchair, asleep with TV on.		will have their family and/or their responsible party queried as to their satisfaction with the activities being provided. Any concerns will be addressed as discovered. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will occur for 10 residents, I day a week for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: As care plans are reviewed the resident's activities preferences list will be part of the review so that any needed or desired changes can be made. This practice will be ongoing. At an in-service held 3/15/2017 for all staff the	

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	c. 11:30 a.m., in assist dining room, in wheelchair, asleep, "I Love Lucy" video playing. d. 12:20 p.m., in assist dining room, in wheelchair, asleep, no activities. Observation on 02/14/2017 at 10:30 a.m. of activity program titled "Current Events" lead by the Activities Director, identified Resident #21 as not present. Resident #21 was observed in their room, in wheelchair, asleep with TV on. Resident #21's clinical record was reviewed on 02/07/2017 at 1:00 p.m. Diagnoses included, but not limited to cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified convulsions, anemia, hyperlipidemia, major depressive disorder, anxiety disorder, muscle weakness, and dysphagia. Review of Resident #21's annual Minimum Data Set (MDS) assessment dated 06/29/2016, indicated a Basic Interview Mental Status (BIMS) score of 05, indicating resident with severe cognitive impairment. Review of Resident #21's annual MDS assessment dated 06/29/2017, indicated resident's activity preferences were listening to music and do things with		following was reviewed: A.) Resident Rights—Choices/Preferences (as related to care and services) B.) Dignity C.) Customer Service D.) Benefits of a strong Activity Program E.) Activity Calendar—Why? Who receives? Where is it posted? F.) Documentation/Care planning/CNA assignment information G.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined. At the monthly QA meetings, the results of the monitoring by the Administrator/Designee will be reviewed. Any concerns will have been addressed as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the	

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	groups of people. Review of Resident #21's quarterly MDS assessment "Functional Status" (Section G) dated 12/21/2017, indicated resident required extensive assistance with locomotion off unit (e.g., areas set aside for dining, activities or treatments). The facility initiated an activities care plan on 06/10/2013 with the following components: Problem/Focus: Resident #21 "enjoys lying in bed and watching TV, however with extra encouragement resident will attend some group activities such as Current Events." Goal "Resident will attend 2 group activities per week and do independent activities of their choice daily." Interventions were initiated on 06/10/2013: -Assess resident's likes and dislikes. -Encourage resident to attend group activities. -Resident will be invited, reminded and escorted to group activities of their choice. As of 02/10/2017, no intervention revisions had be made to the activity care plan.		Administrator until resolved.	

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	Review of Resident #21's "Activity Attendance Calendar" dated January 2017, received from the Activity Director on 02/14/2017, indicated Resident #21 did not attend any group activities during the month of January 2017. Group activity "Current Events" was provided daily during the month of January 2017 with the exception of January 25, 2017 (30 of 31 days). Group activity "Music" was provided on 01/02/2017 and 01/24/2017 (2 of 31 days). Interview with the Activity Director on 02/14/2017 at 10:00 a.m., indicated the facility did not provide Resident #21 with one to one activity programming. Interview with Certified Nursing Assistant (CNA) #6 and #7 on 02/13/2017 at 2:00 p.m., indicated the nursing staff on F Hall did not encourage and/or escort Resident #21 to attend group activities on 02/13/2017 between the hours of 7:00 a.m. and 2:00 p.m. CNA #6 and CNA #7 were unaware of Resident #21's activity interest. Review of activities policy and procedure titled, "Individual Programming/Records" received from the Activity Director on 02/14/2017 at 12:40 p.m., identified as current and dated 2010/2011, indicated Resident #21 met policy guideline:			

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	"Activity staff will provide one to one activity programming for residents who are unable or unwilling to attend group activity programs." 3.1-33(b)(8) 3.1-33(c)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-			

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	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			
	Based on observation, record review, and interview, the facility failed to ensure dental assessments were accurate for 2 of 3 residents who met the criteria for dental review. (Residents #14 and #51) Findings include: 1. The clinical record of Resident #14 was reviewed on 2/13/17 at 9:30 a.m. Diagnoses for the resident included, but were not limited to, protein calorie malnutrition and osteoporosis. He was admitted to the facility on 11/1/16. A Nutritional Risk Assessment, dated 11/1/16, indicated Resident #14 had his own teeth. An admission Minimum Data Set (MDS) assessment for Resident #14, dated 11/12/16, indicated the resident was not edentulous (without teeth). This MDS	F 0278	It is the policy of the facility to ensure that the resident assessments are completed with accuracy, coordination and by certification by an RN for compliance. The dental assessments for Resident #14 and Resident #51 are accurate and complete. Any needed services were addressed/provided. Care plans were revised as indicated. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed to verify that the resident dental assessments were accurate. Any	03/17/2017

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	was signed by the MDS Coordinator, indicating the accuracy of the assessment. An observation of Resident #14, on 2/7/17 at 1:56 p.m., indicated he was edentulous (without any teeth). 2. The clinical record of Resident #51 was reviewed on 2/10/17 at 10:47 a.m. Diagnoses for the resident included, but were not limited to, heart disease and diabetes. He was admitted to the facility on 1/11/17. A Nutritional Risk Assessment,dated 1/11/17, indicated Resident #51, "Has own teeth (may have few broken...teeth)." An admission Minimum Data Assessment (MDS) dated 1/22/17, indicated Resident #51 did not have any broken teeth. This MDS was signed by the MDS Coordinator, indicating it's accuracy. During an interview on 2/7/17 at 1:56 p.m., Resident #51 was observed to have a broken appearing tooth in the front of his mouth. The resident indicated it had been broken for months and he needed to have it pulled. 3.1-31(d)		discrepancies were addressed. Any resident whom it was felt would benefit from care from a dental provider was addressed to meet any needs. The DON/Designee will review completed MDSs weekly with the MDS Coordinator to ensure that the dental portion has been completed accurately based on the findings of an oral screening having been completed and documented. This monitoring will continue until 4 consecutive weeks of zero negative findings has been achieved. After that, 5 completed MDSs will be reviewed weekly by the DON/Designee with the MDS Coordinator for a period of not less than 6 months to ensure ongoing compliance with the dental portion of the MDS. After that, random monitoring will occur. Note: Any concerns will be addressed as found. Care plans will be reviewed and updated as indicated.	

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			At an in-service held 3/7/2017, for the MDS Coordinator, the importance of completing the MDS accurately, timely and completely with emphasis on the dental section being completed accurately based on the findings of an oral screening having been completed and documented was reviewed. Any failure to follow the points of the in-service will result in further education and/or progressive discipline as indicated. At the monthly QA meetings the results of the MDS monitoring by the DON/Designee with the MDS Coordinator will be reviewed. Any concerns will have been addressed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolved.	
F 0279	483.20(d);483.21(b)(1)			

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SS=D Bldg. 00	DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR			

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	recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, record review, and interview, the facility failed to ensure care plans based on the assessment were created or revised with interventions to meet the needs of residents for 2 of 4 residents reviewed for activities (Residents #51 and #21) and 1 of 1 resident reviewed for urinary incontinence (Resident #8). Findings include: 1a. The clinical record of Resident #51 was reviewed on 2/10/17 at 10:47 a.m. Diagnoses for the resident included, but were not limited to, major depressive	F 0279	It is the policy of the facility to ensure that residents have care plans, including interim care plans, in place for residents who reside in the facility. Resident #51 and Resident #21 have comprehensive, accurate care plans in place which include an activity care plan. Resident #8 has a comprehensive, accurate care plan in place which includes the addressing of urinary incontinence. Residents who reside in the	03/17/2017

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	disorder, anxiety, and heart disease. A care plan dated 9/30/16, created from a previous admission (on 9/28/16), indicated the resident was to adjust to facility lifestyle and activities. Interventions included his likes and dislikes would be assessed, he would be encouraged to attend group activities, he could leave activities at any time, and he would be introduced to other residents. This care plan was dated as current through 5/9/17. Resident #51 was readmitted to the facility on 1/11/17. An Activity Admission Review, dated 1/11/17, indicated his interests were computers, video games, spiritual programs and services, outings, pet interaction, keeping up with news, card games, music, going outside for fresh air, social parties, talking, old sitcoms, action and drama movies. Resident #51's activity care plan, originally created on 9/30/16, and current through 5/9/17, was not revised with any personalized interventions after his admission on 1/11/17. On 2/14/17 at 4:00 p.m., the Activity Director indicated he had not revised Resident #51's original care plan with		facility have the potential to be affected by this finding. A facility wide audit was conducted to ensure that all appropriate concerns/issues were care planned with measureable goals and interventions in place. This includes interim care plans for newly admitted residents. Any necessary additions or deletions were documented. The IDT (Interdisciplinary Team) will review 10 care plans weekly making any necessary additions or deletions as indicated. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, 3 care plans will be reviewed by the IDT weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Note: As part of the daily CQI meetings, should review of the 24/72 hour report, review of any new orders received since the prior CQI	

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	more personalized interventions, it was an "oversite" on his part. 1b. The clinical record of Resident #8 was reviewed on 2/14/17 at 4:34 p.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease. An admission Minimum Data Set (MDS) assessment, dated 9/11/16, indicated Resident #8 was always continent of urine. A quarterly MDS, dated 12/1/16, indicated the resident was frequently incontinent of urine. A care plan for Resident #51 addressing her urinary incontinence, with interventions to help prevent complications, was not found in the resident's record. On 2/15/17 at 11:36 a.m., the Director of Nursing indicated a care plan for urinary incontinence should have been created after the MDS assessment on 12/1/16 which indicated the resident was frequently incontinent. 2. Resident #21's clinical record was reviewed on 02/07/2017 at 1:00 p.m. Diagnoses included, but not limited to		meeting as well as any discussion by the IDT indicate that any care plan for any particular resident needs to be updated; the update will occur. At an in-service held for nurses and the IDT on 3/15/2017, the care plan process Including interim care planning and the importance of accuracy and timeliness and completeness of care plans was reviewed and discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings, the reviews of the care plans will be discussed. Any concerns will have been corrected as discovered. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored	

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	cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified convulsions, anemia, hyperlipidemia, major depressive disorder, anxiety disorder, muscle weakness, and dysphagia. Review of Resident #21's annual Minimum Data Set (MDS) assessment dated 06/29/2017, indicated resident's activity preferences were listening to music and do things with groups of people. Review of "Activity Attendance Calendar" dated January 2017, received from the Activity Director on 02/14/2017, indicated Resident #21 did not attend any group activities during the month of January 2017. Group activity "Current Events" was provided daily during the month on January 2017 with the exception January 25, 2017 (30 of 31 days). Group activity "Music" was provided on 01/02/2017 and 01/24/2017 (2 of 31 days). Review of Resident 21's activity care plan on 02/10/2017, indicated no intervention revisions had been made to the activity care plan initiated on 06/10/2013. Interview with the Minimum Data Set		weekly by the Administrator until resolved.	

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	(MDS) Coordinator on 02/15/2017 at 10:15 a.m., indicated no intervention revisions had been made to Resident #21's activity care plan initiated on 06/10/2013. 3.1-35(a)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.			

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	(v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the			

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	participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to review and revise care plans according to residents needs and changes in treatments for 1 of 1 resident reviewed who met the criteria for choices (Resident #24) and 1 of 5 residents reviewed for unnecessary medications (Resident #27). Findings include: 1.) On 2/09/2017 at 9:00 a.m., the clinical record of Resident #24 was reviewed. Diagnosis included but not limited to Non-Alzheimer's dementia. Minimum Data Set Assessment dated 11/01/2016, indicated Resident #24's	F 0280	It is the policy of the facility to ensure that care plans are person centered and that the resident and/or their responsible party can participate in the care planning process. Resident #24 has a comprehensive care plan that accurately addresses needs, changes in treatments and choices. Resident #27 has a comprehensive care plan that accurately addresses their medications. Residents who reside in the facility have the potential to be affected by this finding. As stated to the response to F-279, a facility wide	03/17/2017

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	cognitive skills for Daily Decision Making was severely impaired - "never/rarely made decisions." Transfer - how resident moves between surfaces including to or from; bed, chair, wheelchair, standing position. Resident was coded as total dependence and required two person, physical assist, with all transfers from bed to wheelchair. Care Plan for Resident #24, dated 10/23/14, indicated Focus: Resident #24 is unable to inform staff of their preference. Goal: All of the Resident's needs will be met by staff daily through next review. Target date: 2/15/17. Interventions included, but not limited to: Attempt to find out resident's preference from family, friends, responsible party, and or guardian. On 2/07/2017 at 1:08 p.m., during an interview with Resident #24's guardian, the guardian indicated that the staff wake the resident up at 4:00 a.m. every morning and get him ready for the day. The residents guardian also indicated that she had asked several Certified Nursing Assistants not get him up that early in the morning. On 2/07/2017 at 2:00 p.m., during an interview with the Director of Nursing (DON), the DON indicated that they do		audit was completed to see that all care plans were current and accurate as written. Going forward, in the daily CQI meetings, the review of the 24/72 hour report, new or changed orders as well as IDT discussion will prompt the appropriate Department Head to address and update the care plan appropriately. This process will be ongoing. Further, monitoring of care plans, education on care plans and QA meeting follow up on the care plan monitoring as stated in the response to F-279 will ensure that the care plans are updated and revised for accuracy, including needs, changes in treatments choices and specifics related to medications as well as any other pertinent issues that would need care planning.	

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	not get Resident #24 up at 4:00 a.m., "It's usually around 5:30 a.m." On 2/08/2017 at 9:30 a.m., during an interview with Resident #24's guardian, the guardian indicated based on past preference the resident would prefer to get up around 7:30 a.m. The facility serves breakfast at 8:00 a.m. On 2/15/2017 at 10:15 a.m., during an interview, the MDS Coordinator indicated that Resident #24's Care Plan dated 10/23/14, Focus: Resident is unable to inform staff of their preference, the interventions for that care plan had not been revised since 10/23/2014. On 2/15/2017 at 1:43 p.m., the Administrator provided a policy titled "Care Plans" dated 7/1/11 and indicated it was the current policy being used by the facility. "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Procedure:...5. For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from nurses station to room by the next review of care plan. ...7. All goals and approaches are to be reviewed and			

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	revised as appropriate by a team of qualified persons after each assessment and upon significant change in condition."			
F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.			
	Based on observation, interview, and record review, the facility failed to ensure hand washing procedures were followed	F 0371	It is the policy of the facility to ensure that food is stored, prepared and	03/17/2017

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	related to 2 of 2 kitchen hand washing sinks failing to have hot water temperature of at least one hundred (100) degrees Fahrenheit for 49 of 49 residents. Findings include: Observation of the Dietary Manager and Dietary Staff #3 on 02/07/2017 at 11:00 a.m., indicated the use of hand washing sink, located in the food preparation area, without hot water. Tour of the facility kitchen, with the Dietary Manager, on 02/07/2017 at 11:00 a.m., indicated 2 of 2 hand washing sinks were without hot water. Interview with the Dietary Manager on 02/07/2017 at 11:00 a.m., indicated the hand washing sink located in the food preparation area was not in working order. Hot water temperature, taken by the Dietary Manager, registered fifty seven (57) degrees Fahrenheit. Interview with the Dietary Manager and Maintenance Supervisor on 02/07/2017 at 11:47 a.m., indicated the hand washing sink located in the dish washing/drying area was not in working order. Hot water temperature, taken by the Dietary Manager, registered forty seven (47) degrees Fahrenheit.		served in sanitary conditions approved by local state and federal authorities. The sinks in the Dietary Department have running water that is the proper temp. The hand washing sink water temp is at least as high as 100 degrees Fahrenheit per regulation. The 3 compartment sink in the dietary department is not used as a hand washing sink. Only the sink specified as a hand washing sink is utilized for and by staff to wash their hands. Residents and others who consume food/drinks prepared in the Dietary Department have the potential to be affected by this finding. The Maintenance staff will check and record temps in the hand washing sink in the dietary department 3 days weekly on various shifts and to include some weekend days to ensure that water temps are within the accepted parameters.	

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	Observation of Dietary Staff #3 hand washing on 02/07/2017 at 11:55 a.m., indicated utilization of three compartment sink for hand washing during residents' noon meal preparation. Interview with Dietary Staff #3 on 02/07/2107 at 12:03 p.m., indicated three compartment sink was utilized for hand washing by dietary staff, on 02/07/2017, as an alternative hand washing sink. Interview with the Dietary Manager on 02/07/2017 at 12:10 p.m., indicated all residents currently residing in the facility received food prepared by the facility dietary staff. The Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24-128, indicated, "Sec. 128. (a) Food employees shall...clean their hands and exposed portions of their arms...at a hand washing sink...in water having a temperature of at least one hundred (100) degrees Fahrenheit..." The Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24-130, indicated, "Sec. 131. (a) Food employees shall clean their hands in a hand washing sink...and may not clean their hands in a sink used for food preparation or in a		Any concerns will be addressed and corrected as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, temps will be checked and recorded by the Maintenance staff weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random temps will be taken as well as temps being taken as dictated by the Preventive Maintenance Program. Again, any concerns will be addressed as found. The Dietary Manager/Designee will observe staff washing their hands in the Dietary Department daily 3 days weekly on various shifts and to include some weekend days to be certain that only the hand sink is used for the washing of hands. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring	

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	service sink..." 3.1-21(i)(2) 3.1-21(i)(3)		will continue at least weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed as found. At an in-service held 3/7/2017 for dietary staff and maintenance staff the following was reviewed: A.) Dietary Hand Washing Sink—Water temp? Used for? B) 3 Compartment Sink in the Dietary Department—Used for? C.) Infection Control in the Dietary Department as related to hand washing D.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the result of the monitoring of the hand washing sink water temps in the Dietary	

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			Department by the maintenance staff as well as the hand washing practices monitoring by the Dietary Manager/Designee in the Dietary Department will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolved.	
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 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--			

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	(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure a vial of tuberculin (a method used to	F 0431	It is the policy of the facility to ensure that drugs and biologicals are labeled and stored properly. The	03/17/2017

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	diagnose silent [latent] tuberculosis [TB] infection), was dated when opened, as indicated by facility policy for 1 of 3 vials observed in 1 of 1 medication storage room refrigerator. Findings Include: On 2/10/17 at 9:30 a.m., during the medication storage task, an opened vial of tuberculin and two unopened vials of tuberculin were observed in the medication storage room refrigerator (behind nurses station.) The vial currently being used for injection, was not dated to indicate when it was opened. The tuberculin is used annually and upon admission for residents. The tuberculin is also used upon hire/annually for staff. On 2/10/17 at 9:35 a.m., During an interview, the Licensed Practical Nurse #9, indicated it (tuberculin vial) should have been labeled with the date indicating when it was opened. On 02/13/2017 at 11:06 a.m., The Administrator provided a policy (undated), titled "Tuberculosis Testing" and indicated it was the current policy being used by the facility. "Policy: ...2. Due to the fact that solution must be refrigerated, facility must appropriately label and store it in the medication		undated Tuberculin was destroyed. The new supply of Tuberculin was dated when opened. All vials of Tuberculin are dated when opened and are destroyed 30 days after the date of being opened. Residents or staff who receive PPD/Tuberculin for skin testing have the potential to be affected by this finding. The DON/Designee will monitor all medication refrigerators 3 days weekly on various shifts to include some weekend days to see that any opened vials of Tuberculin are dated and any that none are past the 30 day time frame for use. Any concerns will be addressed/corrected as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, monitoring will occur weekly for a period of not less than 6 months to ensure ongoing compliance. After that,	

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	refrigerator. ...3. If you are opening a new vial, it must be initialed and dated, as it is only good for 30 days after opening the vial." 3.1-25(j)		random monitoring will continue ongoing. At an in-service held 3/15/2017, for nurses, the following was reviewed: A.) Policy and Procedure Tuberculosis (Mantoux) testing B.) Why vials of injectables must be dated when opened and destroyed after 30 days C.) Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the monitoring of the Tuberculin vials by the DON/Designee will be reviewed. Any concerns will have been addressed as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until	

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			resolution.	