STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00286977. Complaint IN00286977 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-684. Survey dates: February 10, 11, 12, 13, 14 & 15 2019. Facility number: 000133 Provider number: 155228 AIM number: 100266080 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 1 Medicaid: 58 Other: 4 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 20, 2019	F 0000	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 the Federal State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for the consideration of paper compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review, the facility failed to ensure the completeness of a "Notice of Transfer or Discharge," specific to the section identified as "Reason for Transfer or Discharge," for 1 of 2 residents reviewed for hospitalizations. (Resident 322) Findings include: The clinical record of Resident 322 was reviewed on 2-14-19 at 9:24 a.m. His diagnoses included, but were not limited to, cellulitis of the right lower extremity. A nurse's progress note, dated 1-21-19 at 6:30 p.m., indicated Resident 322 was experiencing increased pain and was requesting to be sent to the local emergency room. The attending physician was notified of this and agreed to this. A second note on 1-21-19 at 9:04 p.m., indicated Resident 322 was admitted to the local hospital with a diagnosis of cellulitis of the right lower extremity.	F 0623	F623 It has been and will continue to be the policy of this facility to notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Resident 322 was sent to the local hospital on 1/21/19. The transfer discharge paperwork was provided to Resident 322 but facility failed to mark reason for transfer or discharge. While all residents that were transferred or discharged have the potential to be affected all residents were reviewed for the past thirty days and corrective action was taken if needed.	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the "Notice of Transfer or Discharge," form, dated 1-21-19, indicated the portion of this form, entitled "Reason for Transfer or Discharge," was unmarked for this section. On 2-15-19 at 1:15 p.m., LPN 2 provided a copy of a policy entitled, "Admission, Transfer & Discharge Policy and Procedures." This policy indicated, "Notice Transfer or Discharge. Before transfer or discharge the facility will notify the resident and the resident's representative of the reasons for the move in writing..." 3.1-12(a)(6)(A)		Nursing staff in serviced (Attachment 1) on transfer/discharge process and appropriate paperwork that is needed. An audit by the DON or designee will be completed 5 times weekly for six weeks, bi-weekly for six weeks and weekly for three months to ensure compliance (Attachment 2). The results of the audit will be brought to the quarterly QA for review and any recommendations will be followed.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to ensure the plans of care for 1 of 22 residents reviewed for care plans accurately reflected the correct limb that had been amputated and which limb required wound care, care concerns related to noncompliance with care and care related to osteomyelitis. (Resident #322) Findings include: The clinical record of Resident 322 was reviewed 2-14-19 at 9:24 a.m. His diagnoses included, but were not limited to peripheral vascular disease, coronary artery disease, cellulitis of the right lower extremity, nicotine dependency, cerebral artery occlusion with cerebral infarction, occlusion and stenosis of carotid artery, an above the knee amputation of the left leg and	F 0656	F656 It has been and will continue to be the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. While all residents have the potential to be affected all residents were reviewed for the	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	osteomyelitis of the right lower extremity with IV-antibiotic therapy. Several care plans, initiated on 3-1-18, identified Resident 322 as erroneously having a right above the knee amputation. In an interview with LPN 2 on 2-14-19 at 2:30 p.m., she indicated she was unsure why the care plans for Resident 322's admission from the previous year, 2-27-18 to 4-20-18, were reactivated without close scrutiny upon his current admission. LPN 2 indicated when Resident 322 was admitted after the left above knee amputation in 2018, "The hospital told us it was his right leg. But, we should have corrected it and not kept it like that for nearly a year." In an interview on 2-15-19 at 2:36 p.m., with the MDS (Minimum Data Set assessment) Coordinator, she indicated, that Resident 322's care plans were revised to address the correct limbs, the lack of care plans for osteomyelitis and the resident's noncompliance with care after it had been brought to the attention of the facility during the current week. The MDS Coordinator indicated the copies of Resident 322's care plans were provided after the care plans had been revised and was unaware if it was possible to provide copies of care plans in the original format once revisions had been made. On 2-15-19 at 1:15 p.m., LPN 2 provided a copy of a policy entitled, "Comprehensive Assessment and Care Plan Policy." This policy indicated, "It is Heritage House's goal to comprehensively assess and accommodate the resident's needs, strengths, goals, life history and preferences. Heritage House strives to use these assessments to develop and implement a person-centered comprehensive care plan consistent with the		past three months and corrective actions were taken if needed. All new admissions and all new orders will be taken to morning meeting Monday-Friday with the care plans being updated in our clinical morning meeting. Nursing staff in serviced on care planning (Attachment 3). The DON or designee will review all new orders daily in the clinical meeting Monday-Friday and as needed for three months, three times weekly for the following three months and randomly ongoing after that (Attachment 4). Any concerns will be brought to our weekly IDT meeting. All results will be reviewed by QA committee and any recommendations will be followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's rights..." 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2) 3.1-35(c)(1) 3.1-35(d)(1) 3.1-35(d)(2)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed provide nail care for a dependent resident for 1 of 2 residents reviewed for Activities Of Daily Living (ADL) (Resident 10). Finding include: During an observation on 2/11/19 at 11:23 a.m., Resident 10 had long fingernails with black debris underneath them on both hands. During an observation on 2/12/19 at 2:26 p.m., Resident 10 had long fingernails with black debris underneath them on both hands. During an observation and interview on 2/13/19 at 1:38 p.m., Resident 10 had long fingernails with black debris underneath them on both hands. Resident 10's family member indicated they provided the resident with nail care. The family member indicated it was a "battle" to keep them clean because she gets food underneath her fingernails. The family member indicated they had	F 0677	F677 It has been and will continue to be the policy of this facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. While resident 10 did not have nail care provided by staff due to family member becoming upset and wanting to provide nail care himself, the documentation was missing explaining this. And documentation has been updated (Attachment 5). There was no actual harm done to resident 10. All other residents were reviewed and no other residents were affected. An in-service was held for all nursing staff on refusing of	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tried to soak her fingernails with denture tablets to get them clean. During an observation on 2/14/19 at 11:56 a.m., Resident 10 had long fingernails with black debris underneath them on both hands. Review of the record of Resident 10 on 2/14/19 1:09 p.m., indicated the resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, dysphagia, Alzheimer's disease, Chronic Obstructive Pulmonary Disease, hypertension, diabetes and polyosteoarthritis. The Quarterly Minimum Data Set (MDS) assessment for Resident 10, dated 11/11/14, indicated the resident was severely cognitively impaired for daily decision making. The resident had no behaviors of rejection of care. The resident was totally dependent of one person for personal hygiene. During an observation and interview with CNA 4 on 2/15/19 at 9:26 a.m., Resident 10 had long and short fingernails with some black debris underneath them. CNA 4 indicated the resident's family would not allow the aides to clean or trim the resident's fingernails. During an interview with the Director Of Nursing (DON) on 2/15/19 at 10:02 a.m., indicated Resident 10's family member would not let the facility cut or clean the resident's fingernails. The DON indicated she had cleaned and trimmed the resident's fingernails one time and the family member became upset. During an interview with the DON on 2/15/19 at 1:22 p.m., indicated there was no documentation		nail care. (Attachment 6). An audit will be done 5 times weekly by DON or designee for six weeks, bi-weekly for six weeks and one time weekly for three months to ensure appropriate documentation and compliance (Attachment 7). The results of the audit will be brought to the quarterly QA for review and any recommendations will be followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of a plan of care addressing Resident 10's fingernails or that the resident's family did not want the facility to providing nail care. The DON indicated she was not aware if the resident's family member had fingernail clippers and thought the resident's fingernails were so thin that they broke off. The nail care policy provided by Medical Record on 2/15/19 at 2:27 p.m., indicated cleanliness and good grooming contribute to the dignity and self-esteem of every resident. "Nails should be kept short, clean and free of rough edges." "Nails should be groomed weekly, and as indicated." 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality 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. Based on observation, interview, and record review, the facility failed to assess and document an area of facial bruising for 1 of 2 residents reviewed for non-pressure skin condition. (Resident G) Findings include: Resident G's record was reviewed on 2/13/19 at	F 0684	F684 It has been and will continue to be the policy of this facility to ensure that 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	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:04 a.m. His diagnoses included but were not limited to, dementia, anxiety, depression, bipolar disorder, and vitamin B 12 deficiency. His Quarterly Minimum Data Set assessment dated 12/15/18, indicated he was severely impaired in his cognitive daily decision making skills. He had no skin issues. A Skilled Charting note for Resident G dated 1/28/19, indicated he had no new changes to his skin integrity. On 2/11/19 at 1:35 p.m., Resident G was observed with purplish discoloration down the left side of his nose and under his left eye. He indicated he didn't know how the discoloration happened. On 2/13/19 at 11:32 a.m., he continued to have the purplish discoloration down the the left side of his nose and under his left eye. During an interview with RN 3 on 2/13/19 at 1:22 p.m., she indicated she hadn't realized Resident G had any facial bruising. If areas of bruising were observed they were to be documented and she was unable to find the area of facial bruising had been documented. On 2/13/19 at 1:30 p.m., RN 3 indicated another staff member informed her Resident G had been admitted with the area of bruising under his left eye. During an interview with LPN 2 on 2/13/19 at 1:31 p.m., she indicated Resident G had been admitted with discoloration under his left eye in April 2018, but the discoloration was not documented on the admission assessment. On 2/13/19 at 1:34 p.m., LPN 2 indicated it looked like his eye glasses rubbed his face and caused the areas of discoloration. The Skin Condition and Pressure Ulcer Assessment policy provided by Nurse Manager 4 on 2/13/19 at 11:22 a.m., indicated the following:		comprehensive person-centered care plan and the resident's choices. Resident G had a skin assessment done on 2/13/19. (Attachment 8). Care plan updated on 2/13/19. (Attachment 9). On wound weekly observation tool dated 2/20/19 (Attachment 10) bruising under left eye has healed (Attachment 11). All residents have the potential to be affected. All residents will have a skin assessment completed by 2/28/19. Any new areas of concern will be documented, family and MD will be notified. All nursing staff in serviced on new skin areas and proper documentation (Attachment 12). The DON or designee will use a skin audit tool (Attachment 13) to monitor 5 residents for new skin concerns with proper follow up weekly for 3 months (March, April May) then 3 residents for 2 months (June and July), then randomly ongoing to ensure compliance. Audits will be reviewed weekly at IDT meeting. The results of the audits will be reviewed at the quarterly QA meeting and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Any significant changes between seven (7) day assessments will be recorded in the nursing progress notes and skin report noted. ...7. Caregivers are responsible for promptly notifying the charge nurse of skin observations that include: ...b. Bruises...." This federal tag relates to Complaint IN00286977. 3.1-37			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(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 interview and record review, the facility failed to ensure 1 of 1 residents reviewed for dialysis services had the facility's "Hemodialysis Communication" form completed in order to maintain open communication of the residents needs or concerns related to hemodialysis care. (Resident 62) Findings include: Resident 62's clinical record review was conducted on 2-12-19 at 2:49 p.m. His diagnoses included, but were not limited to chronic kidney disease. His clinical record indicated he attended hemodialysis three times weekly at an area dialysis center. Review of Resident 62's "Hemodialysis Communication" binder reflected multiple dates from 11-22-18 to 2-14-19, in which the facility did	F 0698	F698 It has been and will continue to be the policy of the facility to 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. While all residents have the potential to be affected all residents were reviewed for the past three months and corrective action was taken if needed. Resident 62 was the only resident that does receive dialysis at this time.	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not complete the top portion, the facility's portion, of the "Hemodialysis Communication" form. The top portion of the form was to be completed by the facility prior to sending the resident to the dialysis center and included information which included, but was not limited to, vital signs and other pertinent data, such as blood sugar results, laboratory results, medication changes, as needed medications administered and any other changes or concerns that might affect the hemodialysis procedure. These dates indicated were as follows: -11-22-18, top portion blank. -12-13-18, top portion blank. -12-22-18, form missing, but the dialysis center sent a copy of what care and services were provided to Resident 62 during the hemodialysis, as well as any concerns or needs. -12-24-18, form missing, but the dialysis center sent a copy of what care and services were provided to Resident 62 during the hemodialysis, as well as any concerns or needs. -2-9-19 form missing, but the dialysis center sent a copy of what care and services were provided to Resident 62 during the hemodialysis, as well as any concerns or needs. -undated form with the top portion blank and bottom portion, the dialysis center's portion, essentially blank. In an interview on 2-13-19 at 2:36 p.m., with the Director of Nursing, she indicated, "It looks like around the holidays, we didn't get all the documentations done for the pre and post dialysis checks done. I have requested for the dialysis center to fax their information to us. It looks like his dates were changed around some because of the holidays and that his post BP check was documented in the MAR. But I still can't find		All licensed nursing staff were in serviced about care of residents on dialysis. (Attachment 14). The DON or designee will review all residents who are receiving dialysis during morning meeting to ensure that all residents receiving dialysis as ordered do have a pre and post assessment completed. An audit by the DON or designee will be completed every Monday-Friday for three months, three times weekly for the following three months and randomly ongoing after that (Attachment 15). Any concerns will be brought to our weekly IDT meeting. All results will be reviewed by quarterly QA committee and any recommendations will be followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	those [Hemodialysis Communication] forms." On 2-15-19 at 1:15 p.m., LPN 2 provided a copy of a policy entitled, "Dialysis Procedure." This policy indicated, "...Heritage House staff will use the Hemodialysis Communication form as a means of communication with the dialysis center. HH staff will complete the top portion of the communication form and send it with the patient to dialysis..." 3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review the facility failed to have indication for the use of risperdal (antipsychotic medication) and failed to follow the pharmacy recommendation to complete a Gradual Dose Reduction (GDR) on risperdal for 2 of 5 residents reviewed for unnecessary medication use (Resident 26 and Resident 22). Findings include: 1.) During an observation 2/12/19 at 2:34 p.m., Resident 26 was sitting in an geriatric chair. The resident indicated she was doing good.	F 0758	F758 It has and will continue to be the policy of this facility that residents who have not used psychotropic drugs are not given these drugs unless med is necessary to treat a specific condition as diagnosed and documented in the clinical record. Residents who use psychotropic drugs receive GDR'S, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue. All residents have the	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the record of Resident 26 on 02/12/19 02:44 PM indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, reflux, hypothyroidism and angina. The Quarterly Minimum Data Set (MDS) assessment for Resident 26, dated 12/7/18, the resident was severely impaired for daily decision making. The resident had no hallucinations, delusions or behaviors. The resident was admitted to the facility on 10/11/18. The physician recapitulation for Resident 26, dated February 2019, indicated the resident was ordered risperdal 1 milligram (mg) at bedtime for agitation. The original start date of the medication was 10/25/18. The pharmacy recommendation for Resident 26, dated 10/26/18, indicated risperdal should only be used for the following diagnoses: schizophrenia, delusional disorder, bipolar disorder, psychosis in the absence of dementia, medical illness with psychotic symptoms, Tourette's disorder or Huntington disease. "Please review the diagnosis for the use of this antipsychotic." If none of the above diagnosis apply, please consider a dose reduction to risperdal 0.5 mg at bedtime with the goal of discontinuation. The physician signed the recommendation on 10/29/18. During an observation on 2/13/19 at 1:18 p.m., CNA 5 and CNA 6 provided incontinent care for Resident 26. CNA 5 indicated the resident had days that she that she was alert and other days she sleeps a lot. The resident slept thru the care observation. During an observation on 2/14/19 at 12:01 p.m., Resident 26 was in her geriatric chair asleep in the		potential to be affected. All residents will have a review of all medication orders for accuracy, diagnosis and completion for the past 3 months and corrective actions were taken if needed. Resident 26 was reviewed by MD and supporting diagnosis given (Attachment 16) also a GDR was done (Attachment 17). Care plan was updated (Attachment 18). Resident 22 was reviewed and appropriate dx of psychosis for psychotropic medication use had been given upon readmission on 11/5/18. (Attachment 19). GDR received from pharmacy on 2/25/19 for psychotropic medication use (Attachment 20). Reduction began 2/26/19 (Attachment 21). Care plan updated (Attachment 22). All nursing staff in serviced on recommendation provided by pharmacy and on proper procedure in completing recommendations (Attachment 23). The DON or designee will review all new orders for appropriate diagnosis daily in the clinical meeting Monday-Friday and as needed for three months, three times weekly for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restorative dining room. The facility staff attempted two times to wake the resident up to eat with no success. During an interview with the Director Of Nursing (DON) on 2/15/19 at 9:43 a.m., indicated Resident 26 was receiving risperdal for agitation. The DON indicated when the resident first came to the facility she was very aggressive and was exit seeking really bad. The DON indicated the pharmacy recommendation for Resident 26, dated 10/26/18, should of been followed for a GDR. The wound nurse or the floor nurse should have followed up with the physician about the pharmacy recommendation. The DON indicated she would look for documentation of why the resident was put on risperdal. The documentation of Resident 26's behaviors provided by the DON on 2/15/19 at 2:00 p.m., indicated the following indication for the use of risperdal: The progress note for Resident 26, dated 10/12/18 at 9:10 a.m., indicated the resident was ambulating throughout the facility and adamant she was going home. The resident was very agitated and aggressive with staff. The progress note for Resident 26, dated 10/12/18 at 11:30 a.m., indicated the resident was yelling she wanted to go home. The progress note for Resident 26, dated 10/12/18 at 12:33 p.m., indicated the resident was agitated and purposeful exit seeking was noted. The progress note for Resident 26, dated 10/12/18 at 1:56 p.m., indicated the resident was wandering toward exits and looking out. The geriatric		following three months and randomly ongoing after that (Attachment 24). Any concerns will be brought to our weekly IDT meeting. All results will be reviewed by QA committee and any recommendations will be followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychiatric hospital refused to take the resident due to the resident was still getting use to her new placement. The progress note for Resident 26, dated 10/12/18 at 3:00 p.m., indicated the geriatric psychiatric hospital call and stated they would not accept the resident at this time and that her behaviors were related to adjustment issues. The progress note for Resident 26, dated 10/13/18 at 1:30 p.m., indicated the resident was wandering the hallway and going into other residents room. The resident was combative and yelling at staff. The progress note for Resident 26, dated 10/14/18 at 4:33 p.m., indicated the resident was wandering the halls and wandering into other residents room. The resident was screaming and yelling. The resident hit a staff member on the arm. The progress note for Resident 26, dated 10/16/18 at 10:51 a.m., indicated the resident had be up ambulating though out the facility most of the morning. The resident was easily agitated with redirection. The resident became agitated with family on 10/15/18, because she wanted to go home. The progress note for Resident 26, dated 10/16/18 at 9:00 p.m., the resident was anxious and wandering the halls. The progress note for Resident 26, dated 10/17/18 at 11:45 a.m., indicated the resident was ambulating throughout the facility. The resident was easily agitated with redirection. The progress note for Resident 26, dated 10/17/18 at 1:10 p.m., indicated the resident was being sent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the geriatric psychiatric unit. During an interview with the Wound nurse on 2/15/19 at 1:10 p.m., indicated the physician ordered a GDR for Resident 26 on her risperdal to 0.5 mg at bedtime. The Wound nurse was unsure what happened with the Pharmacy recommendation for this GDR on 10/26/18. 2.) Review of the record of Resident 22 on 02/14/19 11:30 AM indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease,COPD, depression, muscle weakness, hypertension, diabetes, acute pancreatitis and Vascular Dementia with behavioral disturbance. The Annual MDS assessment for Resident 22, dated 12/5/18, indicated the resident had no hallucinations, delusions or behaviors. The Physician Recapitulation (Recap) for Resident 22, dated February 2019, indicated the resident was ordered risperdal 1 mg at bedtime for psychosis. The original start date for the medication was 11/2/18. During an interview with the DON on 2/15/19 at 9:58 a.m., indicated Resident 22 was admitted to the geriatric psychiatric and when she returned on 11/2/18, she had the order for the risperdal. The DON indicated she would look for supporting documentation for the use of risperdal. The documentation of Resident 22's behaviors provided by the DON on 2/15/19 at 2:00 p.m., indicated the following indication for the use of risperdal:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 00 B. WING	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The progress note for Resident 22, dated 10/28/18 at 7:04 a.m., indicated the resident was agitated and inappropriate during breakfast. The progress note for Resident 22, dated 10/28/18 at 8:07 p.m., indicated the resident was talking to another resident and said she was going home tonight. The resident refused to move out of entrance way for another resident to get through and was cussing. The resident remained in the hallway making random outburst of curse words. The progress note for Resident 22, dated 10/28/18 at 11:17 p.m., Resident 22 came down the hallway with no pants on. The resident refused to get dressed and hit staff in the abdomen when attempted to help her get dressed. An order was received to send the resident to the geriatric psychiatric hospital. The geriatric psychiatric hospital note for Resident 22, dated 11/2/18, indicated the resident was being sent back to the facility with risperdal 1 mg for aggression/agitation. During an interview with the DON on 2/15/19 at 1:20 p.m., indicated she was not able to find any supporting documentation of psychosis for the use of risperdal for Resident 22. The Nursing drug handbook 2014, indicated Risperdal had a black box warning "fatal CV or infectious adverse events may occur in elderly patients with dementia." "Drug isn't safe or effective in these patients." 3.1-48(b)(1) 3.1-48(b)(2)			