STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 13, 14, 15, 16, 19 & 20, 2018 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 117 SNF: 28 Total: 145 Census Payor Type: Medicare: 28 Medicaid: 85 Other: 32 Total: 145 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/26/18.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to dining for 1 of 2 residents reviewed for dignity and for 1 of 1 dining observations. (Residents 50 and 86) Findings include:	F 0550	**F 550 Resident Rights** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	12/20/2018

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	1. On 11/13/18 at 9:00 a.m., Resident 50 was observed in his room in bed. The resident was awake and his roommate was eating breakfast in front of him. Resident 50 was not served a breakfast tray and the privacy curtain was not pulled between the two residents. On 11/14/18 at 9:08 a.m., the resident's roommate was again eating breakfast in front of him. The privacy curtain was not pulled between the residents. On 11/15/18 at 12:43 p.m., the resident was in his room in bed. The resident was awake at that time and his roommate was eating lunch in front of him. The privacy curtain was not pulled between the residents. On 11/16/18 at 9:28 a.m., the resident was in his room in bed. The resident was awake at that time and his roommate's breakfast tray was on the overbed table in the room. The privacy curtain was not pulled between the residents. The record for Resident 50 was reviewed on 11/15/18 at 3:58 p.m. Diagnoses included, but were not limited to, acquired absence of parts of digestive tract, aphasia (difficulty speaking), dysphagia (difficulty swallowing), aspiration pneumonia and gastrostomy (a tube in the stomach). The Quarterly Minimum Data Set (MDS) assessment, dated 9/19/18, indicated the resident was severely impaired for daily decision making. A Physician's order, dated 6/13/17 and listed as current on the November 2018 Physician's Order Summary (POS), indicated the resident was to receive nothing by mouth (NPO).		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 50 had his privacy curtain pulled between his roommate. Resident 86 was given the appropriate utensils and cued during meals. **1.How the facility identified other residents:** All residents that require staff assistance with meals and enteral feedings were observed for proper assistance and privacy to ensure dignity. **1.Measures put into place/ System changes:** Staff were educated on resident rights and dignity during meal	

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	A Physician's order, dated 10/29/18, indicated the resident was to receive a bolus tube feeding of Jevity 1.2, two cartons every 4 hours. Interview with the Director of Nursing on 11/16/18 at 3:13 p.m., indicated the roommate should not have been eating in front of the resident and the issue would be taken care of. 2. During the lunch meal observation on 11/13/18 at 11:49 a.m., Resident 86 was observed seated at a dining table in her wheelchair. At 12:02 p.m., staff began passing trays. Resident 86 was served mashed potatoes, peas, and fish. The staff assisted the resident with her utensils, she was given a fork to eat her meal. The resident was observed attempting to feed herself the peas from her plate, however, they continued to fall from her fork as she attempted to put them in her mouth. At 12:18 p.m., the RN Nursing Supervisor was observed feeding a resident seated at Resident 86's table. She did not attempt to cue Resident 86 or offer her another utensil. At 12:29 p.m., CNA 1 sat down next to Resident 86 and asked her if she liked peas, the resident indicated she did. The CNA then handed the resident a spoon and cued her for the remainder of her meal. The resident was then able to feed herself the peas and the mashed potatoes. The record for Resident 86 was reviewed on 11/19/18 at 4:07 p.m. Diagnoses included, but were not limited to, vascular dementia, bipolar, schizophrenia, anxiety, and diabetes. The Annual Minimum Data Set (MDS) assessment, dated 10/17/18, indicated the resident was severely cognitively impaired and required extensive 1 staff assistance with eating.		times. **1.How the corrective actions will be monitored:** An audit tool was created to monitor residents needing assistance with meals were given correct utensils and privacy curtains are pulled if roommate is eating and the other resident is NPO. Audit will be completed by DON or designee at least 3 times per week at various times or meals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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	A revised care plan, dated 8/22/17, indicated the resident required assistance with meal consumption. The interventions included, but were not limited to, provide cueing as needed. Interview with the RN Nurse Supervisor on 11/13/18 at 12:37 p.m., indicated she did not notice the resident was having a hard time eating her food. She should have assisted the resident with her meal. 3.1-3(t)(1)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure call light buttons were within reach for 1 of 1 residents during a random observation. (Resident 39) Finding includes: On 11/13/18 at 2:17 p.m., Resident 39 was observed in his room in bed. His call light button was clipped to his sheet on the left side of his bed. When asked if he could reach his call light button he indicated he could not, he would have to wait for assistance until someone passed by or came into his room. The record for Resident 39 was reviewed on 11/15/18 at 6:00 p.m. Diagnoses included left hemiplegia (paralysis), cerebral vascular accident	F 0558	**F 558 Reasonable Accommodations Needs/Preferences** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	12/20/2018

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	(CVA/ stroke), amputation, muscle weakness, lack of coordination, dialysis, diabetes, bipolar, hypertension and heart failure. The Annual Minimum Data Set (MDS) assessment, dated 9/20/18, indicated the resident was alert and oriented and had range of motion impairments to his upper and lower extremities on one side. A care plan, dated 10/4/18, indicated the resident had left hemiplegia related to CVA. The interventions included, but were not limited to, staff to provide assist with ADL (activities of daily living) care as needed. Observation and interview with the Director of Nursing on 11/13/18 at 2:35 p.m., indicated the resident's call light button was affixed on the left side out of reach, and he was unable to reach it. The call light button would be moved to his right side and would be replaced with a press pad. 3.1-3(v)(1)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 39 call light was changed to a press pad and placed on the right side of bed within reach. **1.How the facility identified other residents:** All residents were observed for placement of call lights. **1.Measures put into place/ System changes:** Staff were educated on proper placement of call lights. **1.How the corrective actions will be monitored:** An audit tool was created to observe for proper placement of call lights. Audit will be completed by DON or designee on at least 3 resident 3 times per week at various times/days and units.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(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. §483.10(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. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside			

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	and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure the residents' choices/preferences were honored related to food substitutes for 3 of 4 residents reviewed for choices. (Residents 118, 15, and 139) Findings include: 1. During an interview with Resident 118 on 11/14/18 at 10:37 a.m., he indicated he rarely eats the dinner meal and always asks for a cheeseburger. For the last 5 days he had been told by staff the facility had run out of burgers and he would have to choose something else. He indicated he circles every condiment offered (lettuce, tomato, pickle and onion) and has never received them one time since he has been at the facility. A random kitchen observation on 11/19/18 at 11:40 a.m., indicated fresh tomatoes were delivered on 11/16/18 and the only lettuce the facility had was shredded for salads. The record for Resident 118 was reviewed on 11/14/18 at 3:14 p.m. The resident was admitted on 10/24/18 from the hospital. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, stage 4 kidney disease, congestive heart failure, anemia, and hypoglycemia. The Admission Minimum Data Set (MDS)	F 0561	**F 561 Self determination** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.) Immediate actions taken for those residents identified:** Residents will choose the select meal or any option from the always available menu. Residents may change their menu at any time and be offered a replacement meal at any time. . **2.) How the facility identified**	12/20/2018

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	assessment, dated 10/31/18, indicated the resident was alert and oriented and received insulin during the last 7 days. Physician orders, on the current 11/2018 order summary, indicated a regular texture, no added salt and no concentrated sweets diet. The "always available" list was reviewed on 11/19/18 at 11:45 a.m. The residents were able to choose a chef salad, chicken fingers, hamburger, cheeseburger, and/or grilled cheese if they did not like the main entree. All sandwiches were served with a choice of lettuce tomato, onion, ketchup and mustard. The Performance Food Service invoices were reviewed on 11/19/18 at 12:30 p.m. On 11/2/18, 50 beef patties and 5 pounds of frozen ground beef were received from the food source provider. On 11/6 and 11/9/18, 5 pounds of ground beef were received and no hamburger patties were ordered at those times. On 11/13/18, 10 pounds hamburger patties and 5 pounds of ground beef were received from the food source provider. Interview with the Administrator on 11/19/18 at 2:20 p.m., indicated the previous/Interim Dietary Food Manager was let go on 11/16/18. The Dietary Food Manager was responsible for ordering the food and unless something was over budget he did not look at it on a weekly basis. The Administrator was unaware the kitchen had run out of hamburger patties but would have thought there were other ways to make a hamburger patty by using bulk ground beef.2. During an interview with Resident 15 on 11/13/18 at 3:03 p.m., he indicated he had concerns with meals. The kitchen often ran out of cheeseburgers from the "always available/alternate" menu. Not long ago, they had been out of cheeseburgers for 1 week.		**other residents:** The always available menu includes hamburgers and chicken tenders among several other options. These items are now provided to the facility in larger quantities with the use of FIFO inventory. Items on the always available menu will be stocked and prepared in advance based on historical menu selection trends. **3.) Measures put into place/System changes:** The kitchen food stock is now monitored by SourceTech. The menu is census and ordered use driven. Minimal stock is monitored by inputted preparation and use and automatically reordered per SourceTech. Deliver of such items are twice weekly. **4.) How the correction actions will be monitored:** Meal service will be observed at varied meals and dining locations at least 3 times per week to ensure menu items and “Always Available” items are available. At least 3 resident interviews will be conducted weekly to ensure menu items are available as requested. Any concerns will be placed on a Grievance/Concern form for follow up by the Dietary	

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	The record for Resident 15 was reviewed on 11/19/18 at 11:44 a.m. Diagnoses included, but were not limited to, myoneural disorder, shoulder pain, major depression, and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 8/28/18, indicated the resident was alert and oriented. 3. During the Resident Council Meeting on 11/15/18 at 3:08 p.m., Resident 139 indicated cheeseburgers have not been available from the "always available/alternate" menu, therefore he would order everything on the menu hoping he would receive enough food. He was unsure what would be available and what would not be available. The record for Resident 139 was reviewed on 11/19/18 at 3:09 p.m. Diagnoses included, but were not limited to, orthopedic aftercare, absence of left great toe, lack of coordination, diabetes, and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 11/12/18, indicated the resident was alert and oriented. Interview with the Administrator on 11/19/18 at 2:23 p.m., indicated he was not aware of the residents' concerns and/or the shortage of food from the "always available/alternate" menu. 3.1-3(u)(1)		Manager and Administrator. The Administrator will be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5.) Date of compliance: 12/20/18**	
F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with			

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	respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review and interview, the facility failed to ensure a cognitively impaired resident was free from physical restraints related to lack of an assessment of the one piece jumpsuit for 1 of 1 residents reviewed for restraints. (Resident 40) Finding includes: During an observation on 11/14/18 at 10:10 a.m., Resident 40 was sitting up in his wheelchair with	F 0604	**F 604 Right to be Free from Physical Restraints** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	12/20/2018

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	his shirt zipped up in the back. During an observation on 11/19/18 at 8:15 a.m., Resident 40 was sitting up in his wheelchair, in the dining room eating breakfast, with his shirt zipped up in the back. Resident 40's record was reviewed on 11/15/18 at 3:45 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder, and arthritis. A Physical Restraint assessment, dated 5/14/18, indicated the one piece jumpsuit was used to protect the resident's dignity and deter behaviors for pubic undressing with sexual inappropriate behaviors. A Care Plan, dated 5/14/18, for the use of the physical restraint, indicated an intervention was to evaluate for the reduction of the restraint quarterly and as needed. A Significant Change Minimum Data Set (MDS) assessment, dated 9/21/18, indicated the resident was severely cognitively impaired, used "other" type restraint daily and was an extensive two person assist with dressing. The record lacked a quarterly assessment for the use of the physical restraint after 5/14/18. Interview with the Memory Care Unit Manager on 11/19/18 at 9:21 a.m., indicated the resident had a major decline in last month and had not exhibited behaviors. The midnight nurse who works 6:00 p.m. to 6:00 a.m. should have completed the quarterly restraint assessment. A policy titled, "Restraints," was provided by the		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 40 has been discharged. **1.How the facility identified other residents:** Restraint assessments have been completed on any resident who has a restraint. **1.Measures put into place/ System changes:** Staff were educated on the restraint policy. **1.How the corrective actions will be monitored:** An audit tool was created to monitor restraint assessments. Audit will be completed by DON or designee 1 time per week on all restraints.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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
	Director of Nursing on 11/15/18 at 4:25 p.m. This current policy indicated, "...Guidelines:...3. The use of restraints will be reviewed by the Interdisciplinary Team periodically and at least Quarterly thereafter...." 3.1-3(w) 3.1-26(s)		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
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, record review, and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 3 residents reviewed for skin conditions (non-pressure related). The facility also failed to ensure residents were positioned correctly in wheelchairs for 1 of 1 residents reviewed for positioning. (Residents 50, 56, and 240) Findings include:	F 0684	**F 684 Quality of Care** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	12/20/2018

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	1. On 11/14/18 at 11:29 a.m., Resident 50 was observed with an area of bluish discoloration to his left forearm. On 11/16/18 at 3:30 p.m., with Assistant Director of Nursing (ADON) 1, a fading greenish bruise was observed on the resident's left forearm. The ADON indicated that she would have to see if the resident recently had labs drawn. The record for Resident 50 was reviewed on 11/15/18 at 3:58 p.m. Diagnoses included, but were not limited to, acquired absence of parts of digestive tract, aphasia (difficulty talking), dysphagia (difficulty swallowing), aspiration pneumonia, intellectual disabilities and epilepsy. The Quarterly Minimum Data Set (MDS) assessment, dated 9/19/18, indicated the resident was severely impaired for daily decision making and was an extensive assist for bed mobility and transfers. The November 2018 Physician's Order Summary (POS) indicated the resident was to have weekly skin assessments on Tuesday. The Weekly skin assessment, dated 11/13/18, indicated the resident's skin was intact. There was no documentation related to bruising. An "Other skin condition" report, dated 11/16/18 at 3:35 p.m., indicated the resident had a new skin concern and it appeared to be a discoloration to the left forearm. The resident's arm was hairy making the observation difficult. The area measured 2.0 centimeters (cm) x 2.8 cm and was grayish/green in appearance. The area was to be monitored for 7 days.		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 50 and 56 had skin assessments completed. Resident 240 was placed in a reclined position in the Geri chair. **1.How the facility identified other residents:** All residents had a head to toe skin assessment. Any resident identified with a skin concern was addressed by completing the appropriate assessment. All residents in wheelchairs and recliners were reviewed for proper positioning. **1.Measures put into place/ System changes:** Staff were educated on the skin assessment policy and proper documentation when a skin concern is identified. Staff was	

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	An entry in the nursing progress notes, dated 11/16/18 at 3:50 p.m., indicated discoloration to the left forearm was noted and the resident had labs drawn on the 5th to the left forearm. 2. On 11/13/18 at 2:35 p.m., Resident 56 was observed in bed. At that time there were multiple bruises to both of her forearms. On 11/16/18 at 2:45 p.m., the resident was observed in bed. At that time, only one of her siderails was padded. The other pad was laying on the heat register. The 300 Unit Manager assessed the resident's skin and indicated there were multiple bruises to her forearms. The record for Resident 56 was reviewed on 11/16/18 at 1:33 p.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxemia, muscle weakness, tracheostomy, anemia, heart failure, diabetes mellitus, obesity, kidney disease, and long term use of anticoagulants. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/18, indicated the resident was moderately impaired for decision making. The resident was totally dependent with 2 person physical assist for transfers and bed mobility. The current 10/2018 care plan indicated the resident was at risk for bleeding and bruising related to anticoagulant use. The approaches were to monitor for bleeding, report bruising related to blood draws, and report any abnormal bruising to Physician. Physician orders on the current 11/2018 order summary indicated to place pads to side rails and pillows to help prevent bruising.		also educated on correct positioning for residents. **1.How the corrective actions will be monitored:** Observations will be completed during rounds by DON or designee at least 3 times per week at varied times and units to ensure residents are properly positioned and positioning devices are in place as indicated. The DON or designee will audit weekly skin assessments at least 2 times per week to ensure skin assessments were completed as scheduled, and observe at least 5 residents per week to validate accuracy of skin assessments. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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A weekly skin observation dated 11/7/18 at 9:36 a.m., indicated there were no skin concerns and her skin was intact.

There was no weekly skin observation completed for 11/14/18.

Another skin condition report, dated 11/16/18, indicated small bruises scattered along outer aspect of right forearm measuring 14 centimeters (cm) by 4 cm and multiple bruises to the left forearm measuring 12 cm by 5 cm.

Interview with the 300 Unit Manager (UM) on 11/16/18 at 3:00 p.m., indicated the weekly skin assessment should have been completed on 11/14/18 and the new bruising should have been documented, assessed, and monitored until healed. She was unaware the resident had new bruises.

The current and revised 6/8/18 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the Nurse Consultant on 11/14/18 at 11:30 a.m., indicated a wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions were identified by a licensed nurse.

3. On 11/13/18 at 9:10 a.m., 10:40 a.m., and 12:05 p.m., Resident 240 was observed sitting upright in a geri recliner chair with both of her legs and feet dangling and not supported. The chair was not reclined.

On 11/15/18 at 11:08 a.m., and 4:08 p.m., the resident was observed sitting upright in a geri recliner chair with both of her legs and feet

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	dangling and not supported. The chair was not reclined. On 11/16/18 at 9:20 a.m., the resident was observed sitting upright in a geri recliner chair with both of her legs and feed dangling and not supported. The chair was not reclined. The record for Resident 240 was reviewed on 11/15/18 at 11:13 a.m. The resident was admitted to facility on 11/1/18 from the hospital. Diagnoses included, but were not limited to, adult failure to thrive, difficulty walking, lack of coordination, dysphagia oropharyngeal phase, dementia without behavioral disturbance, high blood pressure, chronic kidney disease, schizoaffective disorder bipolar, VRE (Vancomycin-resistant Enterococcus), personal history of adult neglect, and adult maltreatment. The Admission Minimum Data Set (MDS) assessment, dated 11/8/18, indicated the resident was rarely understood or understands and was severely impaired for decision making. The resident required extensive assist with 1 person physical assist for eating. The resident had physical impairment to one side of her lower extremities. She had no oral problems, weighed 102 pounds, and was on a mechanically altered diet. A nursing admission assessment, dated 11/1/18, indicated the resident was unable to move self and had poor trunk control. A rehabilitation screen, dated 11/7/18, indicated the resident was leaning to the side and forward while up in a wheelchair. Recommend change to reclined geri chair.			

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	Interview with the Assistant Director of Nursing (ADON) 2 on 11/19/18 at 9:00 a.m., indicated the resident was placed in a wheelchair for her safety. Therapy made the decision to place her in a geri recliner. Interview with the Rehabilitation Director on 11/19/18 at 9:18 a.m., indicated he had screened her for the geri recliner due to his observations of her leaning forward and to one side while eating. He indicated the geri chair was to be reclined at all times and only in the upright position for eating. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure palm protectors were applied as ordered for 1 of 4	F 0688	**F 688 Increase/Prevent in ROM/Mobility**	12/20/2018

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	residents reviewed for limited range of motion (ROM). (Resident 25) Findings include: On 11/14/18 at 8:48 a.m. and 10:17 a.m., Resident 25 was observed in her room in bed. The residents hands were each closed in a fist. There were no palm protectors in use at the time. On 11/16/18 at 8:28 a.m., the resident was in her room in bed. There were no palm protectors in use at the time. On 11/19/18 at 2:40 p.m., the resident was in her room in bed. The resident had a rolled washcloth in both of her hands. The record for Resident 25 was reviewed on 11/19/18 at 11:18 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia without behavioral disturbance, major depressive disorder and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 9/10/18, indicated the resident was severely impaired for daily decision making and had a functional range of motion limitation to both sides of her upper and lower extremities. Restorative nursing services were provided for passive range of motion but not for splint or brace assistance. A Physician's order, dated 10/5/17, and listed as current on the November 2018 Physician's Order Summary (POS), indicated bilateral palm protectors were to be applied by restorative daily. The palm protectors were to be applied in the a.m. and off in the afternoon.		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 25 had palm protectors placed to both hands. **1.How the facility identified other residents:** All residents requiring anti-contracture devices were observed for placement. **1.Measures put into place/ System changes:** Staff were educated on ensuring anti-contracture devices are applied as ordered.	

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	The current plan of care, which was reviewed in September 2018, indicated the resident had an alteration in musculoskeletal status as evidenced by contractures related to Parkinson's, dementia and rhabdomylosis (a syndrome related to muscle injury). Interventions included, but were not limited to, provide positioning devices/splints as ordered. Restorative nursing had documented passive range of motion had been provided the last 14 days but there was no documentation related to application of the palm protectors. The November 2018 Treatment Administration Record (TAR) indicated the palm protectors were to be applied at 8:00 a.m. and removed at 12:00 p.m. The palm protectors were signed out as being applied and removed per schedule November 1st thru 19th. Interview with Assistant Director of Nursing 1 on 11/19/18 at 3:30 p.m., indicated the resident had palm protectors in her room and they should have been applied as ordered. 3.1-42(a)(2)		**2.How the corrective actions will be monitored:** An audit tool was created to observe for anti-contracture devices applied as ordered. Audit will be completed by DON or designee at least 5 times per week at various times to ensure devices are in place as ordered. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

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	adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents were free from hazards related to a used lancet lying on a table in a resident's room and toothpaste and mouth wash in a resident room who resided on the Special Care Memory Unit for 2 of 4 residents reviewed for accident/hazards. (Residents 118 and 96) Findings include: 1. During a room observation on 11/14/18 at 8:35 a.m., 10:30 a.m., and 11:00 a.m., Resident 118 was not in his room. At that time there was a used lancet device with the needle exposed on top of the resident's table. There was no sharps container in his room. The resident's room was located right across from the therapy department, where residents were observed ambulating with assistive devices and propelling their wheelchairs on their own. During a room observation on 11/15/18 at 12:25 p.m., the same lancet was observed on top of the resident's table with the needle exposed. The record for Resident 118 was reviewed on 11/14/18 at 3:14 p.m. The resident was admitted on 10/24/18 from the hospital. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, stage 4 kidney disease, congestive heart failure, anemia, and hypoglycemia. The Admission Minimum Data Set (MDS) assessment, dated 10/31/18, indicated the resident was alert and oriented and received insulin during the last 7 days.	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 118 was discharged. Resident 96 personal care items were removed and placed in locked area. **1.How the facility identified other residents:** No residents currently in facility are performing their own blood sugar checks. All resident rooms and areas were	12/20/2018

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	Interview with LPN 1 on 11/15/18 at 1:10 p.m., indicated she was aware the resident had brought his own glucometer from home as well as the test strips and the lancets and was performing glucometer checks on himself. Interview with the Assistant Director of Nursing (ADON) 2 on 11/15/18 at 1:30 p.m., indicated she was unaware the resident had his glucometer as well as the equipment in his room. The resident should have been disposing the used lancets into a sharps container. She indicated she would inform him not to leave the used lancets on top of the table in his room, which was viewable from the hallway. The current and undated, "Needle Sharps-Handling and Disposal" policy, provided by the Director of Nursing on 11/19/18 at 9:30 a.m., indicated used needles and other sharp objects must be placed in a puncture-resistant biohazard container.2. In the Memory Care locked Unit, the following was observed: In Resident 96's bathroom, on 11/13/18 at 10:49 a.m., a 1/4 of bottle of Listerine mouthwash and a tube of toothpaste were easily accessible on the shelf. The labels indicated to "Keep out of reach of children". In Resident 96's bathroom, on 11/15/18 at 10:05 a.m., a 1/4 of bottle of Listerine mouthwash and 2 tubes of toothpaste were easily accessible on the shelf. The labels indicated to "Keep out of reach of children". There were two cognitively impaired residents who shared this bathroom and there were 6 known residents who wander into other residents' rooms.		checked for hazards. **1.Measures put into place/ System changes:** Staff were educated on storage and disposal of potential hazards and resident safety. A self-administration assessment will be completed on any residents identified as wishing to self-perform glucose checks to ensure they are capable of proper storage and disposal of lancets and biohazard container is available. **1.How the corrective actions will be monitored:** Rounds will be completed at least 5 times per week at varied times/shifts and units to observe for any potential hazards. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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	Resident 96's record was reviewed on 11/15/18 at 9:04 a.m. Diagnoses included, but were not limited to Alzheimer's disease. Interview with Memory Care Unit Manager, on 11/15/18 at 10:58 a.m., indicated there were 6 known residents that wander into other residents' rooms and the mouthwash and toothpaste should have been stored in a locked drawer. Policy titled, "Chemical Labeling & Storage," was provided by the Director of Nursing on 11/20/18 at 8:15 a.m. This current policy indicated, "...Guidelines:...5. Hazardous chemicals shall be maintained in a locked area...." 3.1-19(4) 3.1-45(a)(1) 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure nutritional supplements were provided as ordered for residents with a history of weight loss as well as not providing the correct diet for 2 of 7 residents reviewed for nutrition. (Residents 3 and 240) Findings include: 1. On 11/15/18 at 5:50 p.m., Resident 3 was seated in the Main dining room waiting for dinner. The resident was not served any beverages at that time. At 6:22 p.m., the resident received her dinner. The resident's tray card indicated she was to receive a health shake with meals. The resident did not receive a health shake with her meal. On 11/16/18 at 8:15 a.m., the resident was eating her breakfast in the Main dining room. The resident was not served a health shake. At 1:25 p.m., the resident was eating her lunch. Again, she was not served a health shake. On 11/19/18 at 8:20 a.m., the resident was eating her breakfast in the Main dining room. The resident was served coffee and orange juice. There was no health shake served at that time. The record for Resident 3 was reviewed on 11/15/18 at 1:02 p.m. Diagnoses included, but were not limited to, hypertension, major depressive disorder, dementia without behavioral disturbance, heart failure and pressure ulcer to the right heel.	F 0692	**F 692 Nutrition/Hydration Status Maintenance** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 3 had no harm from missing health shakes Resident 240 was given correctly textured foods, no harm noted from missing supplement not given. **1.How the facility identified**	12/20/2018

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	155156	A. BUILDING 00 B. WING	11/20/2018

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	On 10/5/18, the resident's weight was documented as 114 pounds. On 10/26/18, the resident's weight was documented as 99 pounds. A Physician's order, dated 10/26/18, indicated the resident was to receive health shakes with meals for weight loss. The Annual Minimum Data Set (MDS) assessment, dated 11/6/18, indicated the resident was cognitively impaired and needed supervision with eating. An unprescribed weight loss and weight gain was also coded. Interview with Assistant Director of Nursing 1 on 11/19/18 at 3:42 p.m., indicated if a resident was to receive a health shake with meals, it was to be documented on the tray card and provided by dietary.2. On 11/13/18 at 12:24 p.m., Resident 240 was observed sitting in a geri recliner chair in the 400 unit dining room. At that time, an activity aide served the resident her meal tray and placed the plate of food in front of her. The resident was served a regular textured diet, which included a piece of fried fish, coleslaw, and tater tots. At 12:29 p.m., CNA 3 sat down to feed the resident. The CNA fed the resident bites of the regular textured fish, the coleslaw and the tater tots. At 12:36 p.m., the CNA gave another CNA the resident's plate of food and asked her to bring the resident a pureed diet. At 12:37 p.m. the Assistant Director of Nursing (ADON) 2 brought a plate of pureed food and CNA 3 continued to feed the resident. During the noon meal, the resident did not receive any supplements or a can of Ensure (a nutritional supplement). On 11/15/18 at 12:24 p.m., the resident was observed in the dining room eating lunch. She		**other residents:** An audit was completed to identify residents with special/restricted diets, altered texture, . and supplements. **1.Measures put into place/ System changes:** Nursing and dietary staff were educated on ensuring residents receive the correct diet and supplements as ordered. **1.How the corrective actions will be monitored:** Audits will be performed at least 5 times per week at varied meals and locations to ensure correct diet and/or supplements are given as ordered. The Dietary Manager/designee and DON/designee will both be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	was served pureed turkey pot pie, and pureed carrots. She had a glass of red juice and water in front of her to drink. There was no can of Ensure noted for the resident. On 11/15/18 at 5:56 p.m. the resident was observed in the dining room waiting for dinner to be served. She was had a glass of orange drink in front of her. At 6:25 p.m., the resident was served her pureed food. There was no can of the nutritional supplement given to her. The record for Resident 240 was reviewed on 11/15/18 at 11:13 a.m. The resident was admitted to facility on 11/1/18 from the hospital. Diagnoses included, but were not limited to, adult failure to thrive, difficulty walking, lack of coordination, dysphagia oropharyngeal phase, dementia without behavioral disturbance, high blood pressure, chronic kidney disease, schizoaffective disorder bipolar, VRE (Vancomycin-resistant Enterococcus), personal history of adult neglect, and adult maltreatment. The Admission Minimum Data Set (MDS) assessment, dated 11/8/18, indicated the resident was rarely understood or understands and was severely impaired for decision making. The resident required extensive assist with 1 person physical assist for eating. The resident had physical impairment to one side of her lower extremities. She had no oral problems, weighed 102 pounds, and was on a mechanically altered diet. The Nursing admission assessment, dated 11/1/18, indicated the resident had a chewing and swallowing problem and had no natural teeth. The resident's diet was pureed texture with regular liquids.		**5) Date of compliance: January 7, 2019**	

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The current care plan, dated 11/1/18, indicated unable to consume regular consistency foods and required a mechanically altered diet. The approach was to provide a pureed diet as ordered and ensure plus (supplement) with meals.

A Physician's order on the current 11/2018 order summary, indicated regular diet with pureed texture and thin liquids. Ensure plus, one can with meals at 8:00 a.m., 12:00 p.m., and 5:00 p.m.

A nutritional assessment, completed by the Registered Dietitian (RD) and dated 11/5/18, indicated the resident's body mass index was 14.8 and she was severely underweight consistent with adult failure to thrive. The resident received a pureed diet with ensure three times a day.

The resident's weights were as followed:
11/1/18 109 pounds
11/2 103 pounds
11/4 100 pounds
11/6 102 pounds
11/15 101 pounds

The Medication Administration Record (MAR) for the month of 11/12018 indicated the Ensure plus was signed out as being administered as followed:
On 11/1/18 the 5 p.m. dose was signed out at 9:55 p.m.
On 11/2/18 the 8 a.m. can was signed out at 10:03 a.m.
On 11/3/18 the 5 p.m. dose was signed out at 9:38 a.m.
On 11/4/18 the 8 a.m. and 12 p.m. cans were signed out at 11:05 a.m.
On 11/5/18 the 8 a.m. can was signed out at 9:20 a.m.
On 11/6/18 the 8 a.m. can was signed out at 9:35

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	a.m. On 11/6/18 the 12 p.m. can was signed out at 1:29 p.m. On 11/7/18 the 8 a.m. can was signed out at 9:33 a.m. On 11/11/18 the 8 a.m. can was signed out at 9:18 a.m. On 11/13/18 the 8 a.m. can was signed out at 9:25 a.m. On 11/17/18 the 12 p.m. can was signed out at 1:24 p.m. Interview with ADON 2 on 11/15/18 at 4:15 p.m., indicated the resident did receive a regular texture diet on 11/13/18 for lunch. She should have received a pureed diet and the ensure supplement was to be given with meals. 3.1-46(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral			

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	eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (a tube in the resident's abdomen) medications were administered following the facility's policy and procedure for 1 of 1 gastrostomy tube medication observations. (Resident 239) Finding includes: On 11/16/18 at 8:50 a.m., RN 1 was preparing medications for Resident 239. The RN placed one Acetaminophen 325 milligrams (mg) tablet into the medication cup. The RN indicated the resident received his medications by the way of a gastrostomy tube (g-tube) and she proceeded to crush the tablet. The RN proceeded to the resident's room and diluted the medication with water. The resident's tube feeding pump was placed on hold. The RN then disconnected the feeding and placed a syringe into the port of the g-tube. The RN pulled back on the syringe and checked for residual. She did not check for placement by the way of an air bolus. The RN drew up water into the syringe and proceeded to push the plunger into the g-tube. The RN drew up the medication into the syringe and proceeded to push the plunger into the g-tube. The RN drew up water into the syringe and proceeded to push the plunger into the g-tube to flush the tube. The RN did not let the water flushes nor the medication infuse by gravity.	F 0693	**F 693 Tube Feeding Mgmt/Restore Eating Skills** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 239 was discharged. **1.How the facility identified other residents:** All residents who have G-tubes have the potential to be affected. **1.Measures put into place/**	12/20/2018

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	The record for Resident 239 was reviewed on 11/20/18 at 10:05 a.m. Diagnoses included, but were not limited to, ventilator associated pneumonia, dysphagia (difficulty swallowing), severe sepsis with septic shock, chronic respiratory failure and gastrostomy status. A Physician's order, dated 11/10/18, indicated the resident could receive Acetaminophen 325 mg, 1 tab via g-tube every 6 hours as needed for mild pain on a scale of 1-5. The facility policy titled, "Medication Administration-Gastrostomy or Nasogastric Tube" was provided by the Director of Nursing on 11/19/18 at 4:26 p.m. and identified as current. The policy indicated the tube should be checked for proper placement by drawing 5-10 cubic centimeters (cc's) of air into a syringe, place stethoscope on the abdomen just above the waist, insert barrel of syringe into g-tube, unclamp tube, gently inject air into the port and listen to the stomach for gurgling or growling sound, and aspirate to visually verify stomach contents. After verifying placement, connect a 60 milliliter (ml) piston to the end of the enteral tube and flush tube with approximately 30 ml's of tap water via gravity prior to medication administration. Pour the prescribed medication into the barrel of the syringe with the syringe held approximately 6 inches above the nares. Interview with the Director of Nursing on 11/20/18 at 10:00 a.m., indicated the RN should have checked for placement with an air bolus as well as residual, and both the water flush and the medication should have been infused by gravity. 3.1-44(a)(2)		**System changes:** Staff were educated on proper procedure for checking placement of G-tube and administering G-tube medications. **1.How the corrective actions will be monitored:** The DON or designee will observe at least 2 licensed nurses per week administer medications via G-tube until all licensed nurses pass the competency, then will randomly observe 1 G-tube administration per week on varied licensed nurses thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered for 1 of 2 residents reviewed for oxygen. (Resident 43) Finding includes: On 11/14/18 at 11:10 a.m., Resident 43 was seated in his wheel chair in the Main dining room. The resident's oxygen tubing was not in place and was resting on his chest. On 11/15/18 at 11:11 a.m., the resident was in his room in bed. The resident's oxygen concentrator was set at 1 1/2 liters and his nasal cannula was not in his nose. At 4:09 p.m., the resident was propelling himself in his wheelchair. The resident positioned himself next to the Nurses' station. The resident's nasal cannula was not in place at this time. Staff were also in the area at the time. At 4:24 p.m., Assistant Director of Nursing 1 assisted the resident with his oxygen tubing. The record for Resident 43 was reviewed on 11/15/18 at 11:23 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes, anxiety disorder, vascular dementia	F 0695	**F 695** **Respiratory/Tracheostomy Care and Suctioning** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 43 oxygen tubing was	12/20/2018

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	without behaviors and schizophrenia. A Physician's order, dated 8/9/18, indicated the resident was to receive oxygen at 2 liters every shift for shortness of breath. The current plan of care, dated 9/25/18, indicated the resident had oxygen therapy related to shortness of breath. The interventions included, but were not limited to, oxygen via nasal cannula at 2 liters. Interview with the Director of Nursing on 11/19/18 at 4:04 p.m., indicated the oxygen should have been set at the correct flow rate and the resident should have been assisted in a more timely manner when his oxygen was not in place. 3.1-47(a)(6)		placed with correct liter flow as ordered **1.How the facility identified other residents:** All residents requiring oxygen were observed for proper placement and liter flow as ordered. **1.Measures put into place/ System changes:** Staff were educated on ensuring oxygen tubing is placed appropriately and oxygen liter flow is administered as ordered. **1.How the corrective actions will be monitored:** The DON/designee will complete observations on varied residents at least 5 times per week at varied times/shifts to ensure oxygen is in place and set to proper liter flow The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 7, 2019**	
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 record review and interview, the facility failed to provide the necessary care and services for a resident who received hemodialysis related to not completing the pre and post dialysis assessments for 1 of 1 residents reviewed for dialysis. (Resident 99) Finding includes: The record for Resident 99 was reviewed on 11/15/18 at 3:47 p.m. The resident was admitted to the facility on 9/12/18 from the hospital. Diagnoses included, but were not limited to, fluid overload and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 9/19/18, indicated the resident was alert and oriented. The resident received dialysis. Physician orders, dated 9/26/18, indicated dialysis on Tuesdays, Thursdays, and Saturdays.	F 0698	**F 698 Dialysis** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:**	12/20/2018

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	The pre dialysis assessment was not completed on 11/3, 11/10 and 11/15/18. The post dialysis assessment was not completed on 11/6/18. Interview with the Assistant Director of Nursing (ADON) 2 on 11/19/18 8:55 a.m., indicated the pre and post dialysis assessments were to be completed on dialysis days. 3.1-37(a)		Resident 99 was assessed with no negative findings. **1.How the facility identified other residents:** All residents requiring dialysis were reviewed and assessments completed. **1.Measures put into place/ System changes:** Orders for pre and post dialysis assessments will be entered on MAR for documentation of assessment findings on residents receiving dialysis. Licensed staff will be educated on completing and documenting pre and post dialysis assessments. **1.How the corrective actions will be monitored:** An audit will be completed by DON or designee on residents receiving dialysis at least 3 times per week to ensure assessments are completed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
F 0728 SS=D Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has			

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	worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).			
	Based on record review and interview, the facility failed to ensure a CNA from another state took the competency test for the State of Indiana within 120 days of employment for 1 of 63 CNAs in the facility whose certifications were reviewed. (CNA 2) Finding includes: The employee files were reviewed on 11/20/18 at 8:30 a.m. A CNA from another state did not have a current Indiana CNA certificate to work. CNA 2 was hired on 6/18/18. The CNA had worked 10/20, 10/21, 10/23, 10/24, 10/26, 10/29-10/31/18, 11/3, 11/4, 11/6, 11/7, 11/9, and 11/12/18. Interview with the Human Resource Director on 11/20/18 at 9:15 a.m., indicated the CNA was termed (terminated) on 11/12/18, however she did work post 10/18/18 and therefore, past her allowed 120 days to get an Indiana certificate. 3.1-14(e)	F 0728	**F 728 Facility Hiring and Use of Nurse Aide** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** C.N.A was discharged on 11/12/2018	12/20/2018

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	155156	A. BUILDING 00 B. WING	11/20/2018

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			1.How the facility identified other residents: Other C.N.A employee files were reviewed to ensure current Indiana C.N.A certificates were current. **1.Measures put into place/ System changes:** Any staff requiring an Indiana license or certificate will have their current license/certificate placed in a binder. Staff with out-of-state certificates/licenses will be placed in a tickler file within the same binder for review at least once per month until certification is completed or until 120 days expire. Additionally, the Human Resource director will provide the scheduler with a cut- off date so certificates/licenses will be reviewed before continued scheduling at 120 days. Human Resources Director will be responsible for oversight of these audits. **1.How the corrective actions will be monitored:** The results of these audits will be	

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			reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure medications were obtained and dispensed as ordered related to psychotropic and pain medications for 2 of 2 residents reviewed. (Residents 90 and 15) Findings include: 1. Interview with Resident 90 on 11/13/18 at 9:32 a.m., indicated the facility often runs out of her psychotropic medications and she has to wait to receive them. The record for Resident 90 was reviewed on 11/15/18 at 11:44 a.m. Diagnoses included, but were not limited to, chronic pain, osteoarthritis, bipolar, borderline personality disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/22/18, indicated the resident was alert and oriented and cognitively intact for decision making. The November 2018 Physician's Order Summary (POS) indicated the resident received the following medications: - Ativan (an anti-anxiety medication) 1 milligram (mg) twice a day for anxiety. - Seroquel (an antipsychotic medication) XR 24	F 0755	**F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	12/20/2018

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	hour 300 mg, give 2 tablets at bedtime. - Lithium Carbonate (a mood stabilizer) 450 mg in the morning for bipolar. - Lithium Carbonate tablet 300 mg at bedtime for bipolar. The October 2018 Medication Administration Record (MAR) indicated the resident did not receive her 9:00 a.m. dose of Lithium on 10/17/18 and did not receive her 9:00 a.m. dose of Ativan on 10/23/18. An entry in the nursing progress notes, dated 10/17/18 at 8:53 a.m., indicated the Lithium was not available to administer. Pharmacy and the Nurse Practitioner were notified. Documentation in the nursing progress notes, dated 10/23/18 at 8:01 a.m., indicated awaiting arrival from pharmacy. The September 2018 MAR, indicated the resident did not receive her 9:00 p.m. Lithium on 9/11/18 and she did not receive her 9:00 p.m. Seroquel on 9/15/18. An entry in the nursing progress notes, dated 9/11/18 at 9:00 p.m., indicated the resident's medication was not available. Documentation in the nursing progress notes, dated 9/15/18 at 9:18 p.m., indicated the resident's Seroquel was unavailable from pharmacy. The August 2018 MAR, indicated the resident did not receive her 8:00 p.m. Ativan on 8/1/18 due to the medication not being available and she did not receive her 8:00 a.m. dose of Ativan on 8/2/18 due to the medication not being available.		*federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 90 and Resident 15 had no harmful effects from medication missed **1.How the facility identified other residents:** All residents receiving medication could be affected. All residents were reviewed for medications missed and appropriate notifications done. **1.Measures put into place/ System changes:** Licensed nurses and QMA's will be educated on the availability of medications, including procedure for re-ordering medications and use of emergency drug kit as	

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	An entry in the nursing progress notes dated 8/2/18 at 10:42 a.m., indicated Ativan 1 mg twice a day for anxiety, awaiting medications from pharmacy. Interview with the Director of Nursing (DON) on 11/19/18 at 3:30 p.m., indicated when a medication needed to be refilled, staff could click the reorder button on the MAR unless a new script was required. In that case, a new prescription would need to be obtained from the Nurse Practitioner or Physician and faxed to pharmacy. Interview with the DON on 11/20/18 at 10:20 a.m., indicated the resident should have received her medications as ordered. 2. Interview with Resident 15 on 11/13/18 at 2:43 p.m., indicated he had concerns related to his medications not being available. On occasion, his Xanax (an anti-anxiety medication) and Morphine (a pain medication) were not refilled on time and he has missed doses. The record for Resident 15 was reviewed on 11/19/18 at 11:44 a.m. Diagnoses included, but were not limited to, myoneural disorder, shoulder pain, major depression, and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 8/28/18, indicated the resident was alert and oriented and he received scheduled pain medications. Physician's orders indicated the following: - Morphine Sulfate ER 30 mg (milligrams), dated 9/6/17, give every 8 hours (12 a.m., 8 a.m. and 4 p.m.) for chronic pain - Xanax/Alprazolam 1 mg, dated 9/13/17, give 0.5 mg 2 times daily (morning and evening) for anxiety.		appropriate. **1.How the corrective actions will be monitored:** The DON/designee will audit for medication availability on at least 5 residents per week to ensure medications are obtained and dispensed as ordered. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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	The November 2018 Medication Administration Record (MAR) indicated the resident did not receive his pain medication on 11/6/16 at 12 a.m., 8 a.m., and 4 p.m. He did not receive the evening dose of his anti-anxiety medication on 11/9/18. Interview with the Director of Nursing on 11/19/18 at 4:02 p.m., indicated the medications can be reordered and available the same day unless a script was needed, the resident's medications should have been available. 3.1-25(g)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure multi-dose vials of insulin and insulin pens were dated when opened for 1 of 4 medication carts observed and for 1 of 2 medication rooms observed. (200 unit medication cart and the 300 unit medication room) Findings include: 1. On 11/20/18 at 8:57 a.m., an open vial of Novolog insulin was observed in the 200 unit medication cart. The insulin vial was not dated when opened. 2. On 11/20/18 at 9:06 a.m., the following was observed in the 300 unit medication room: - Two Basaglar insulin pens were not dated when opened. - One open vial of Novolog insulin was not dated when opened. - One open vial of Lantus insulin was not dated when opened. Interview with RN 2 at the time, indicated the insulin pens and insulin vials should be dated when opened. Interview with the Nurse Consultant on 11/20/18 at 10:20 a.m., indicated the insulin pens and insulin vials should have been dated when opened. The facility policy titled, "Medication Storage" was provided by the Nurse Consultant on 11/20/18 at 10:20 a.m. and identified as current. The policy indicated the following: "Once any medication or biological package is opened,	F 0761	**F 761 Label/Store Drugs and Biologicals** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** The undated Insulin was removed from the medication cart and medication storage room. **1.How the facility identified other residents:** All medication carts and medication storage rooms were observed to ensure all medications requiring opened dates were dated per policy.	12/20/2018

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	facility staff should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." 3.1-25(j)		**1.Measures put into place/ System changes:** Licensed nurses and QMA's will be educated on proper labeling of date open and monitoring for expiration date on medications with a shortened expiration date once opened. **2.How the corrective actions will be monitored:** An audit tool was created to observe for date opened on required medications in medication carts and medication storage rooms. Audit will be completed by DON or designee at least 2 times per week. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

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F 0803 SS=E Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, record review, and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect the 5 residents in the facility who received a pureed diet. (The Main Kitchen) Finding includes: During an observation of 5 servings of puree, on 11/19/18 at 11:41 a.m., the Interim Dietary Manager (DM), placed 4 scoops of smoky chicken macaroni	F 0803	**F803 Menus meet Resident Needs** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	12/20/2018

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	and cheese combination in the puree blender. He then placed a ladle of milk into the blender mixture. The DM indicated he did not know the size of the ladle that he used, and it was a guess of 1 ounce of milk used. The DM proceed to blend the mixture, placed an unmeasured amount of thickener into the puree blender, then added 2 more ladles of milk. The recipe indicated to use 5 ounces of milk, and lacked an indication to use thickener. Interview with the DM, on 11/19/18 at 11:53 a.m., indicated he did not follow the recipe. 3.1-20(i)(1) 3.1-20(i)(4)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Interim Dietary Manager was inserviced by Regional Dietician on reading and following recipes. **1.How the facility identified other residents:** All residents on puree foods have the potential to be affected. **1.Measures put into place/ System changes:** All cooks were inserviced by the Dietary Manager to assure accuracy in following recipes and providing puree foods. **1.How the corrective actions will be monitored:** The Dietary manager will audit	

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			recipe and puree food production for accuracy at least 5 meals per week at varied meals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food and utensils were properly stored in sanitary conditions in the freezer, dry storage, the main Kitchen area and the unit food pantries. The facility also failed to ensure a Cook's mustache was covered during food service. This had the potential to affect 135 residents who had an opportunity to receive a snack from the food pantry and who ate from the main kitchen and 19 residents who were served food in the Memory Care Unit. Findings include: 1. During the initial tour of the kitchen on 11/13/18 at 8:47 a.m. with the Interim Dietary Manager (DM), the following was observed: a. In the freezer, a bag of French Fries was open and exposed to air. b. In the dry storage area, there was an unlabeled container with a white powdery substance. Per the Interim DM, the substance was potato pearls. c. In the Kitchen area, there was a bin of oatmeal with a cracked lid, exposing the oatmeal to the air. d. On the Kitchen shelves, 11 bins of utensils were stored uncovered, had debris in the containers and several of the containers were stored below waist level.	F 0812	**F 812 Food Procurement, Storage** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Bag of French Fries, potato pearls, oatmeal, yogurt, loaf of bread, bulk containers of cereal, Country Lime Lemonade, Vegetable Juice, whipped cream, 2L Pepsi, cup of coleslaw, honey thick lemon water, peanut and jelly sandwiches, as identified by the 2567 were discarded. A beard	12/20/2018

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	2. On the Memory Care Unit on 11/19/18 at 3:39 p.m. with the Unit Manager (UM), the following was observed in the food pantry: a. In the refrigerator, there were yogurts with a used by or dispose of date of 11/14, a pitcher of tea labeled used by or dispose of by 11/17, a thickened apple juice opened and not labeled with a date, a vanilla pudding open and exposed to the air without an open date. b. A loaf of bread, with a dark black area on the side of the bread, was on the counter top ready to be used. c. 2 bulk containers containing cereal were unlabeled and undated. d. Inside the ice machine, there was a yellow substance surrounding the filter and there was a black substance in the water reservoir tray. 3. In the 200 Hallway Food Pantry, with LPN 2 on 11/19/18 at 4:15 p.m., the following was observed: a. In the refrigerator, a resident's bottle of Country Time Lemonade had been opened and had a label indicating it was to be used by or disposed of by 11/13/18. b. In the refrigerator, a resident's bottle of Vegetable Juice had been opened and had a label indicating it was to be used by or disposed of by 11/13/18. c. In the refrigerator, a container of whipped cream had been opened and had a label indicating it was to be used or disposed of by 11/16/18. d. In the refrigerator, a 2 liter of Pepsi that had		net was provided the identified employee. The refrigerator temperature monitoring chart a reviewed for accuracy on unit 300. The ice machine collection tray was cleaned. **1.How the facility identified other residents:** All residents receiving an oral diet have the potential to be affected. **1.Measures put into place/ System changes:** Dietary and nursing staff were educated on food storage, labeling, storage of utensils, refrigerator temperatures/completion of temperature log and use of hair and facial hair/beard restraints. Signage was placed to reinforce appropriateness of food storage and labeling. Routine cleaning by the ice machine vendor is scheduled. **1.How the corrective actions will be monitored:**	

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	155156	A. BUILDING 00 B. WING	11/20/2018

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	been opened and had a label indicating it was to be used or disposed of by 11/16/18. 4. In the 300 Hallway Food Pantry, with LPN 3 at 4:40 p.m., the following was observed: a. The refrigerator temperature was 56 degrees Fahrenheit. Interview with LPN 3 at that time, indicated no one had recently opened and used the refrigerator. The Refrigerator Temperature log, indicated the last temperature documented was on 11/13/18. b. In the refrigerator, there was a cup of coleslaw marked to be used or disposed of by 11/17/18. c. In the refrigerator, a container of honey thick lemon water was open and exposed to the air with an open date of 11/15. d. In the refrigerator, there were 5 peanut butter and jelly sandwiches that were hard to touch and had a label indicating they were to be used or disposed of by 11/18/18. 5. During a breakfast observation in the Memory Care Unit, on 11/14/18 at 8:40 a.m., the Interim DM was observed plating food for 19 residents without using his beard guard to cover his approximately 1/4 inch mustache. Interview with the Interim DM on 11/14/18 at 8:49 a.m., indicated he had never covered his mustache and did not know he needed to cover it up. Interview with the new Interim DM, on 11/20/18 at 9:01 a.m., indicated mustaches should be covered as well with the beard guards, the ice machines are rented and cleaned by the company the facility rents them from, the housekeeping and Nursing		Kitchen food storage areas and nutrition pantries on the units will be audited at least 3 times per week to ensure food is properly stored and labeled, temperatures/temperature logs completed and within acceptable range, refrigerators and food storage areas are clean including ice machines, and utensils are properly stored. The Dietary Manager will observe food preparation and food service at least 5 times per week at varied meals to ensure proper hygiene and hair/ facial hair is covered. The Dietary Manager and Administrator are responsible for oversight of these audits. **5) Date of compliance: 12/20/18**	

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	department are responsible for the food pantries, and any food, even the residents' personal food stored in the units pantries, have to be used or disposed of in 3 days after having been opened. Policy titled, "Staff Hygiene," was provided by the Interim Dietary Manager on 11/15/18 at 12:12 p.m. This current policy indicated, "...Guideline:...e. Beards are to be trimmed and covered with face mask of snood...." Policy titled, "Cleaning/Sanitizing-Ice Machine, Ice Chest & Scoop," was provided the Dietary Manager from the sister facility, on 11/20/18 at 10:34 a.m. This current policy indicated, "...Ice Machine:...8. Record on cleaning log, the date ice machine was cleaned." Policy titled, "Food Labeling and Dating for Pantry Refrigerators," was provided the Dietary Manager from the sister facility, on 11/20/18 at 10:34 a.m. This current policy indicated, "...Once refrigerated items are properly stored with name dates, they need to be used or disposed of within 3 days...." Policy title, "Handling Clean Equipment and Utensils," was provided by the Interim Dietary Manager on 11/15/18 at 12:12 p.m. This current policy indicated, "...Procedure:...2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from contamination by splashes and dust...4. Other stored utensils should be covered or inverted wherever possible...." Policy titled, "Food Storage," was provided by the Interim Dietary Manager on 11/15/18 at 12:12 p.m. This current policy indicated, "...Standards:...3. Perishable foods shall be stored at the following			

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	temperatures to protect against spoilage: Fresh fruits and vegetables 40-41 degrees; Dairy products and eggs 33-41 Degrees...4. Refrigerator and freezer temperature readings will be taken daily and recorded. 5. All stored food products will be covered, identified and dated...10. Ingredient bins and bulk food containers will be properly labeled to identify food products stored...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure hand hygiene was performed correctly after glove removal by a Respiratory Therapist on the Ventilator Unit. This had the potential to affect 8 residents residing on the Ventilator unit. The facility also failed to ensure personal protective equipment (PPE) was available for a resident who was in contact isolation on the 400 unit. This had the potential to affect 34 residents residing on the 400 unit. (Residents 94 and 240) Findings include: 1. On 11/13/18 at 11:37 a.m., Respiratory Therapist (RT) 1, the Rehabilitation Director, and several occupational and physical therapy assistants were observed in Resident 94's room all dressed in PPE (which included gloves and gowns). The resident was in contact isolation for C-difficile toxin and there was a three tiered plastic container of disposable gowns, masks and gloves noted in the bathroom. The RT walked into the resident's bathroom and removed the disposable gown and gloves and placed them in the garbage can in the bathroom. She turned on the water from the faucet in the resident's bathroom. She wet her hands, applied soap, rinsed her hands and dried them in less than 3 seconds. There was no rubbing or friction of her hands with the soap. She left the room and walked into her office, located across the hall from the resident's room. At 11:43 a.m., the RT donned another gown and gloves and returned to the room. At that time, the therapy department staff were leaving the room.	F 0880	**F 880 Infection Prevention & Control** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** Resident 94 and resident 240 had no harmful effects **1.How the facility identified other residents:** All residents have potential to be affected.	12/20/2018

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	At 11:47 a.m., the RT removed her gown and gloves and threw them away in the trash can in the resident's bathroom. She wet her hands with water and applied soap to wash. She was observed washing her hands for 3 seconds and dried them with a paper towel. Again there was no rubbing or friction noted with her hands while she washed them. The record for Resident 94 was reviewed on 11/16/18 at 11:35 a.m. The resident was admitted to the facility on 10/16/18 from the hospital. Diagnoses included, but were not limited to tracheostomy, seizures, quadriplegic, C-difficile toxin, respiratory failure, ventilator dependent, and spinal cord injury. The Significant Change Minimum Data Set (MDS) assessment, dated 11/9/18, indicated the resident was rarely and/or never understood. Physician's orders on the current 11/2018 order summary, indicated contact isolation for C-difficile toxin. Interview with the Director of Nursing (DON) on 11/16/18 at 11:00 a.m., indicated she would expect staff to include friction and rubbing of their hands while washing them. The current 1/10/18 "Hand Hygiene/Handwashing" policy provided by the DON on 11/16/18 at 10:00 a.m., indicated "Procedure for washing hands with soap and water: Wet hands with running water with fingertips down. Apply hand washing agent. Lather all surfaces of hands and wrists and between fingers. Vigorously rub hands together to create friction for at least 15-20 seconds. Rinse hand thoroughly holding under running water."		**1.Measures put into place/ System changes:** Staff will be educated on proper handwashing technique and personal protective equipment needed for types of isolation. MDS was educated on care planning of residents with conditions requiring isolation precautions. **1.How the corrective actions will be monitored:** Handwashing/ hand hygiene observations will be performed on at least 5 staff members per week in varied departments and shifts. The DON or designee will complete an audit of residents with isolation precautions at least 3 times per week to ensure personal protective equipment is available and an appropriate care plan is in place. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	2. Resident 240's room was observed on 11/14/18 at 9:14 a.m. and 11:30 a.m., and on 11/15/18 at 11:43 a.m. and 4:00 p.m. At those times, there was a sign on the door which indicated to ask staff before entering the room. There was no personal protective equipment (PPE) setup located in the room. The record for Resident 240 was reviewed on 11/15/18 at 11:13 a.m. The resident was admitted to the facility on 11/1/18 from the hospital. Diagnoses included, but were not limited to, adult failure to thrive, difficulty walking, lack of coordination, dysphagia oropharyngeal phase, dementia without behavioral disturbance, high blood pressure, chronic kidney disease, schizoaffective bipolar disorder, VRE (Vancomycin-resistant Enterococcus), personal history of adult neglect, and adult maltreatment. The Admission Minimum Data Set (MDS) assessment, dated 11/8/18, indicated the resident was rarely understood or understands and was severely impaired for decision making. The resident required extensive assist with 1 person physical assist for eating. The resident had physical impairment to one side of her lower extremities. She had no oral problems, weighed 102 pounds, and was on a mechanically altered diet. There was no care plan for any type of isolation. Physician orders, dated 11/1/18, indicated contact isolation for lice and history of VRE to the urine. Interview with the Assistant Director of Nursing (ADON) 2 on 11/15/18 at 4:15 p.m., indicated the resident was in contact isolation for head lice,		**5) Date of compliance: 12/20/18**	

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	which had been treated one time while at the facility and was scheduled to be treated again. The resident also had VRE in her urine. Interview with ADON 2 on 11/15/18 at 5:30 p.m., indicated if the resident was in contact isolation then an isolation set up was to be available in the room with gowns, gloves, and masks if needed. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the residents' environment and the kitchen was clean and in good repair related to marred walls, doors, and furniture, dusty bathroom vents, rusty toilet bolts, lime buildup on faucets, dirty carpet, dirty floors, and dirty shelves and air vents for 4 of 4 units and 1 of 1 kitchen. (The Special Care, 200, 300, and 400 units, and Main Kitchen) Findings include: 1. During the Environmental tour on 11/19/18 at 1:15 p.m. with the Maintenance and Housekeeping Supervisors, the following was observed: Special Care Unit: a. Room 123, the bathroom ceiling vent was dusty. The bathroom door was marred. Four residents shared the bathroom. b. Room 124, the bathroom ceiling vent was dusty. The raised toilet seat had chipped and peeling paint. There was rust all over the seat.	F 0921	**F F921 Safe/Functional/Sanitary, Comfortable Environment** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:**	12/20/2018

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	Four residents shared the bathroom. c. Room 109, the bathroom door and wall were marred. Two residents shared the bathroom. d. Room 102, the carpet was frayed by the threshold at the door entrance. The toilet bolts were rusty and exposed. Three resident shared the bathroom. e. Room 115, the plastic cover for the activity calendar was cracked. There was a hole in the bathroom door. There was a large amount of lime build up on the faucet and the piping under the sink was rusted and pulling away from wall. Two residents shared the bathroom. f. Room 108, the toilet bolts were rusty and exposed. The ceiling vent was dusty. The door frame was marred and had peeling paint. There was a moderate amount of a brown substance under the toilet bowl. Interview with the Housekeeping supervisor at that time, indicated the bathroom had already been cleaned. Two residents shared bathroom. g. Room 122, the baseboard was pulling away from the wall in the bathroom. There was a moderate amount of debris and discolorations on the bathroom floor. The ceiling vent was dusty and there were cobwebs on the sprinkler head. Two residents resided in the room and shared the bathroom. 200 unit a. Room 213, the walls in room and along edge of closet were marred and in need of painting. The arms and legs of the straight back chair were scratched and marred. The privacy curtain was		A maintenance, housekeeping and administrative tour was conducted and items easily repairable were initiated prior to survey completion. Rooms and areas identified as having marred walls were covered or patched and painted. Any holes in the walls were repaired and painted. Rusted areas were covered or replaced. Pitted and/or rusted pipes were covered or replaced. Lime build up was treated with the appropriate cleaner. Vents were cleaned (kitchen and identified rooms) shelves, furniture, dressers, chairs were polished, scratches covered, upholstery cleaned. Bumpers and corner guards were added as needed in high traffic areas. Privacy curtains were cleaned, and hooks replaced as indicated. The resident fan was cleaned. The toilet seat was replaced in room 124, baseboard was reattached as needed, cobwebs were dusted away per maintenance, enteral feeding drips were cleaned from the wall and pole. All floors on the 400 unit were cleaned with a commercial carpet cleaning device. Kitchen walls were covered or resurfaced, water leak is being repaired by an outside vendor, Grill and kettle were scrubbed, floor power sprayed, debris among cooking apparatuses were cleaned, walls were repaired.	

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	missing hooks. The bathroom ceiling vent was dusty. One resident resided in the room and used the bathroom. b. Room 203, the walls in room were paint chipped and marred. Two residents resided in the room. c. Room 201, the privacy curtain was stained and missing hooks. There was a moderate amount of lime build up around the faucet and there was no drain stopper in the bathroom sink. Two residents resided in the room and 4 resident shared the bathroom. d. Room 206, the wall behind the bed and next to the bed was scratched and marred. The privacy curtain was stained. The nightstand was scratched and marred. The standing fan with resident's last name on it, had a thick accumulation of dust on the blades and cover. There was lime build up on the faucet. Two residents resided in the room and 3 residents shared the bathroom. e. Room 220, The bedroom walls were scratched and marred. The bathroom ceiling vent was dusty and there was lime build up on the bathroom faucet. Two residents resided in the room and 4 shared the bathroom. 300 unit a. Room 304, the bedroom walls were marred. There was a large hole in the wall behind the second bed in the room. Two residents resided in the room. b. Room 301, the bedroom walls were marred. The wood was chipped on the bathroom door. Two residents resided in the room and shared the		**1.How the facility identified other residents:** A maintenance, housekeeping and administrative tour was conducted on all resident rooms and common areas of the facility. **1.Measures put into place/ System changes:** Based on the facility wide inspection, a list was made for all necessary areas needing additional cleaning, repaired or replacement. The list was then prioritized based on need, resident risk and materials available for timely improvement. The housekeeping and laundry Manager will conduct and document rounds at least 3 times per week to inspect cleanliness of the facility and include at least 3 resident rooms on each unit. Department managers will complete Angel Rounds to observe for cleanliness and any maintenance or housekeeping concerns noted will be reported and documented in the morning manager meeting at least 3-5 times per week. Maintenance work orders will be completed and placed on the repair log for issues identified through observations and rounds.	

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	bathroom. c. Room 302, there was dried brown enteral feeding on the wall and register near bed 2. Two residents resided in the room. d. Room 319, the bathroom vinyl flooring was cracked by the toilet bowl and the ceiling vent was dusty. One resident resided in the room and used the bathroom. e. Room 317, the tube feeding pole had a large amount of dried enteral feeding noted on the base. One resident resided in the room. 400 unit a. Room 422, the bathroom door was gouged and the wall in the bathroom by the ceiling had a hole in it. One resident used the bathroom. b. Room 430, the carpet was dirty in the room. The resident had indicated he spilled water on the floor and his wife wiped it up with a white wash cloth. The cloth was black after wiping up the water. The resident indicated the housekeeper never vacuums his rooms, just sweeps the carpet with a broom and picks up the crumbs. Interview with the Housekeeping Supervisor at that time, indicated he had thought the carpets were cleaned after the residents's discharge, but was not sure. He indicated the room was to be swept everyday. He indicated there was no documentation of when each room's carpet was cleaned, just when the unit was to be cleaned and carpet cleaner had broke down again a week ago. The project schedule for floor care was reviewed. There were no specific rooms identified as being		The repair log will be reviewed weekly by the Maintenance Director for completion. Kitchen areas were placed on a routine cleaning schedule. The Food Services manager will complete observations and audit of cleaning schedule at least 3 times per week. The Administrator will be responsible for oversight of all audits. **1.How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12/20/18**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	cleaned or going to be cleaned just units were scheduled. Interview with the Maintenance and Housekeeping Supervisors on 11/19/18 at 2:10 p.m., indicated all of the above was in need cleaning and/or repair. Interview with the Administrator on 11/19/18 at 2:20 p.m., indicated he would expect the Housekeeping Supervisor to document the rooms when the carpet has been cleaned. He also indicated it would not be possible to clean the carpet in resident rooms after they discharge on the 400 unit (Medicare unit). He agreed a better system needed to be in place to keep track of when the carpets were cleaned on every unit.2. In the Kitchen, during the initial tour on 11/13/18 at 8:47 a.m., the following was observed with the Interim Dietary Manager (DM): a. In the cooler, there was a red substance spilled on the floor near the door. b. On the shelf of a food prep area, there were pieces of egg shells, dust, visible food crumbs and an open packet of thickener. c. On the floor under the tilt skillet, there was a build up of a black substance. Interview with the Interim DM at that time indicated the grease fryer used to be there and it was probably a grease build up. d. In the corners of the kitchen floor, there was a dark build up with food debris in the corners. e. There were gouges in the wall with chipped paint by the tilt skillet.			

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	f. A dark substance build up was on the surface of the grill and between the grill ridges. g. A dark green substance covered 3 of the 4 ceiling vents. h. By the ceiling vents, there was a fuzzy dark green substance hanging from the ceiling. i. Visible food debris was noted by where the clean cutting boards were stored. j. 2 multi-use lunch bags were stored and touching the clean cutting boards on the shelf. k. The clean cutting boards were stored below waist level uncontained. l. There was peeling paint throughout the kitchen's ceiling. Interview with the Interim DM at the time of the tour indicated the deep cleaning was scheduled to be done on Tuesday, the grease on the floor has been on there for years and he then observed and indicated the daily cleaning schedule lacked documentation for November. A policy titled, "Cleaning Schedule," was provided by the Interim Dietary Manger on 11/15/18 at 12:12 p.m. This current policy indicated, "...Procedure:1. The food service manager is responsible for developing a cleaning schedule for the department. He/she will also monitor compliance and overall cleanliness and sanitation of the department...3. A cleaning schedule will be posted and employees will initial and date tasks when completed...." 3.1-19(f)			

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