STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOW LAKES	200 MEADOW LAKE DR MOORESVILLE, IN 46158

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 10, 11, 12, 13, 16, 17, and 18, 2018 Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF: 16 SNF/NF: 96 Residential: 49 Total: 161 Census Payor Type: Medicare: 18 Medicaid: 69 Other: 25 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on April 24, 2018.	F 0000	**This plan of correction constitutes this facility' s written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Meadow Lakes is respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.**	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family			

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

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	members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on interview and record review, the facility failed to ensure Resident Council grievances were acted upon and promptly resolved for residents who complained of food being served cold for 8 of 8 members who attend resident council meetings. (Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 8, Resident 38)	F 0565	**F565** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 25 receives food	05/11/2018

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	Findings include: During the Resident Council meeting on, 4/13/2018 at 10:26 a.m., the council members indicated the food is often served cold. They have complained about it for a few weeks, but the facility has not done anything to correct the situation. There were 8 residents in attendance at the Resident Council meeting. (Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 8, Resident 38) Review, on 4/16/2018 at 4:00 p.m., of the Resident Council Meeting Minutes indicated the following: a. On 3/5/2018 at 3:00 p.m., the Resident Council concerns were, food not hot. There were 7 residents in attendance at the meeting. (Resident 25, Resident 72, Resident 107, Resident 109, Resident 70, Resident 8, Resident 85). The Resident Council minutes log lacked documentation of follow up for the Resident Council meeting on 3/5/2018, in regard to food not being served hot. b. On 3/19/2018 at 3:15 p.m., the Resident Council concerns were, food not hot. There were 8 residents in attendance at the meeting. (Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 76, and one resident who no longer resides at the facility). A review of the Resident Council Meeting Follow up, dated 3/20/18, for the Resident Council meeting on 3/19/2018, indicated: food temped (temperature) before and during each meals and logged. The form was signed by the department manager. Interview with residents at the Resident Council meeting on 4/13/2018 at 10:26 a.m.,		at appropriate temperatures · Resident 72 receives food at appropriate temperatures · Resident 107 receives food at appropriate temperatures · Resident 28 receives food at appropriate temperatures · Resident 109 receives food at appropriate temperatures · Resident 70 receives food at appropriate temperatures · Resident 8 receives food at appropriate temperatures · Resident 38 receives food at appropriate temperatures **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All department managers will be in-serviced on the Resident Council and Grievance Policies by the CEC/designee including prompt follow-up and resolution by May 11, 2018 · Dietary staff will be in-serviced on proper food temperatures/obtaining temperatures by the CDM/designee by May 11, 2018 · Resident Food Council meeting held on 4/30/18 to identify any concerns. **What measures will be put into place or what systemic changes you will make to**	

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	indicated the food continues to be served cold and they feel staff have not responded to their concerns. During an interview, on 4/17/2018 at 1:00 p.m., with the Administrator, she indicated the facility had gone through a change with dietary staff but things are starting to get better. On 4/17/2018 at 11:30 a.m., the DON provided the facility's policy, "Resident Concerns and Grievances" with a revised date of 9/2017, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... It is the policy of this facility that resident, representative or family concerns/grievances occurring during the resident's stay shall be responded to promptly ..." 3.1-3(l)		**ensure that the deficient practice does not recur?** · The Activity Director will ensure that all concerns voiced at the Resident Council Meeting were appropriately addressed within 7 days by signing the Resident Council Meeting Follow Up Form and presenting it to the Resident Council President for signature. · The Executive Director will review all resident council meeting minutes and Monthly Grievance Trend Form to ensure that they have resolution and that concerns are not ongoing. Repeat concerns will have a plan of action developed to ensure systematic change is made to address grievances per facility policy and presented at the QAPI meeting. · The Activity Director will ensure that resident council grievances have been reviewed and accepted on the next Resident Council Meeting and documented on the Resident Council Meeting Minutes which will be reviewed and signed by the Resident Council President and Executive Director monthly · All department managers will be in-serviced on the Resident Council and Grievance Policies by the CEC/designee including prompt follow-up and resolution by May 11, 2018 · Dietary staff will be in-serviced on proper food	

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			temperatures/obtaining temperatures by the CDM/designee by May 11, 2018 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Activities and Grievances QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may			

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	have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those			

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	grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less			

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	than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure resident grievances were acted upon and promptly resolved for residents who complained of food being served cold for 3 of 3 residents reviewed for grievances. (Resident 75, Resident 91, Resident 28) Findings include: On 4/16/2018 at 4:01 p.m., the DON provided copies of Concern/Grievance forms. The forms indicated the following: a. On 3/13/2018 at 1:16 p.m., Resident 75 indicated her soup was cold. A follow up with the department head on 3/20/2018, indicated, " ...plate warmer and steam table working properly and at right temps (temperature). Staff educated on checking temps of food regularly and filling out log ..." b. On 3/20/2018 at 5:00 p.m., Resident 91 indicated food temps are a concern. A follow up with the department head on 3/22/2018, indicated, " ... temping food during cooking process and before service ..." c. On 4/4/2018 at 1:30 p.m., Resident 28 indicated food is served cold. A follow up with the department head on 4/4/2018, indicated, " ... temping food to make sure the food is hot ..." During an interview, on 4/17/2018 at 1:00 p.m., with the Administrator, she indicated the facility had gone through a change with dietary staff but things are starting to get better. The following interviews were conducted during	F 0585	**F585** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 75 receives food at appropriate temperatures · Resident 91 receives food at appropriate temperatures · Resident 28 receives food at appropriate temperatures **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice · All department managers will be in-serviced on the Grievance Policy by the CEC/designee including prompt follow-up and resolution by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All department managers will be in-serviced on the Grievance Policy by the CEC/designee including prompt follow-up and resolution by May 11, 2018	05/11/2018

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	the survey. During an interview, on 4/10/2018 at 3:35 p.m., Resident 214 indicated the food is always served cold. During an interview, on 4/11/2018 at 9:55 a.m., Resident 313 indicated her food is always served cold. During an interview, on 4/11/2018 at 1:55 p.m., Resident 111 indicated her food is always served cold. During an interview, on 4/12/2018 at 9:34 a.m., Resident 83 indicated the food is often served cold. During an interview, on 4/12/2018 at 9:45 a.m., Resident 105 indicated the food is often served cold. During an interview, on 4/12/2018 at 10:26 a.m., Resident 215 indicated the food is always served cold. On 4/17/2018 at 11:30 a.m., the DON provided the facility's policy, "Resident Concerns and Grievances" with a revised date of 9/2017, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... It is the policy of this facility that resident, representative or family concerns/grievances occurring during the resident's stay shall be responded to promptly ..." 3.1-7(a)(2)		· The Social Services Director will be in-serviced by the Executive Director on the Grievance trending log by May 11, 2018 · Grievance trending log will be brought to the QAPI meeting monthly and reviewed for trends · The Executive Director will review all resident grievances daily Monday through Friday to ensure that all grievances are resolved promptly per facility policy. The Executive Director will only sign off on the grievance after ensuring resident/family satisfaction. · A Monthly Grievance Trend Form will be completed to identify trends and repeat concerns. Repeat and trended concerns will have a plan of action developed to ensure systematic change is made to address grievances per facility policy and presented at the QAPI meeting overseen by the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Grievances QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	

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			Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on interview and record review, the facility failed to ensure staff completed a Significant Change in Status Assessment (SCSA) on a Minimum Data Set (MDS) assessment within 14 days of identifying a significant change for 1 of 1 resident reviewed for hospice care (Resident 37). Findings include: On 4/13/18 at 11:00 a.m., Resident 37's clinical record was reviewed. Diagnosis included, but were not limited to: dementia, rheumatic mitral stenosis, anorexia, and Alzheimer's disease. A review of Resident 37's April, 2018, physician's orders included an order for hospice on 5/4/17, related to a diagnosis of Alzheimer's disease.	F 0637	**F 637** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Significant Change MDS was initiated on resident 37 on 6/1/17 after deficiency was recognized with a review of the plan of care following completion to ensure the resident's status is accurately reflected in the MDS coding and plan of care. **How will you identify other**	05/11/2018

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	Resident 37's hospice start of care (SOC) began on 5/5/17. With a hospice start date of 5/5/17, indicated 14 days as 5/18/17, making the SCSA dated 6/1/17; 14 days late. During an interview, on 4/17/18 at 12:10 p.m., the MDS Coordinator did not deny the SCSA was completed late. 3.1-31(d)(1)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents who receive hospice care have the potential to be affected by the alleged deficient practice ·The MDSC will complete an audit of all residents currently identified as receiving hospice services to ensure a significant change MDS was completed and that hospices services was identified on the most recent MDS assessment and care plan. A Significant Change MDS assessment will be completed for any resident receiving hospices services not identified on the most recent MDS assessment and care plan by May 11, 2018. ·All Significant Change MDS assessments identified as untimely (incomplete status >14 days after identification of resident's significant change) will be completed by May 11, 2018 ·MDS Coordinator and MDS Assistant will be in-serviced by May 11, 2018 by the company RAI Specialist or designee on accuracy of MDS related to coding of hospice care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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F 0656 SS=D	483.21(b)(1) Develop/Implement Comprehensive Care Plan		·MDS Coordinator and MDS Assistant will be in-serviced by May 11, 2018 by the company RAI Specialist or designee on accuracy of MDS related to coding of hospice care. ·The MDSC will review a list of residents on hospice weekly and compare the resident's status to the most recent MDS assessment and care plan, initiating a significant change MDS assessment if applicable based on MDS 3.0 Manual Significant Change Criteria. ·RAI Specialist or designee will conduct a weekly audit to ensure MDS is coded correctly for residents who receive hospice care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·RAI Process QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	155751	A. BUILDING 00 B. WING	04/18/2018

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review, and interview, the facility failed to implement a care plan relative to the monitoring of side effects of an antipsychotic medication for 1 of 5 residents monitored for unnecessary medications care plans (Resident 51) and failed to ensure staff developed a care plan for a resident with a bruise for 1 of 3 residents reviewed for skin conditions. (Resident 103). Findings include: 1.) On 4/12/18 at 1:00 P.M., Resident 51's clinical record was reviewed. Diagnoses included, but not limited to, Parkinson's disease and unspecified dementia with behavioral disturbance. April 2018 Physician's order, with a start date of 3/16/18, for Seroquel (an antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder), 25 mg twice daily. The clinical record indicated the medication was current, and the resident was receiving the medication as ordered. There was no care plan in place relative to the monitoring of side effects of the antipsychotic medication, Seroquel. During an interview, on 4/12/18 at 3:45 P.M., the Director of Nursing indicated there was no care plan in place relative to side effects monitoring of the Seroquel as there should have been.	F 0656	**F656** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 51 had a care plan in place for “psychotropic” medication side effects, initiated 9/23/16. The care plan was updated to add “antipsychotic” side effects · Resident 51 with new order to monitor for antipsychotic side effects · Resident 103 no longer resides at this facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents receiving antipsychotic medication have the potential to be affected by the alleged deficient practice · All residents who admit with bruising have the potential to be affected by the alleged deficient practice · An audit of all residents on antipsychotic medication will be done by May 11, 2018 to ensure that residents have a care plan relative to the monitoring of side	05/11/2018

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	On 4/17/18 at 11:30 A.M., the Director of Nursing provided the facility's policy, "Comprehensive Care Plan Review", original date 1/2010, revised date 11/2017, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "....the care plan will include measurable goals and resident specific interventions based on resident needs...to promote the highest level of functioning including medical, nursing, mental, and psychosocial needs..." 2. On 4/11/2018 at 9:29 a.m., Resident 103 was observed to have a healing, half dollar sized green and yellow bruise above her left eye. During an interview with the resident she indicated she obtained the bruise in November of 2017, after a fall. During at interview, on 4/12/2018 at 2:58 p.m., Certified Nursing Assistant 1 (CNA) indicated she had assisted Resident 103 to bed and had not noticed a healing bruise above the resident's left eye. During at interview, on 4/12/2018 at 3:00 p.m., Licensed Practical Nurse 1 (LPN) indicated the healing bruise above Resident 103's left eye was old and was there when she admitted to the facility. During at interview, on 4/12/2018 at 10:54 a.m., the Director of Nursing (DON) indicated she talked to the son last night and he confirmed Resident 103 fell in November of 2017, and obtained the bruise above her left eye at that time. The DON indicated there should have been documentation of the bruise. Resident 103's clinical record was reviewed on 4/13/2018 at 10:50 a.m. Diagnoses included, but		effects of an antipsychotic medication · The IDT will be in-served on the Comprehensive Care Plan Review including initiating care plans for side effect monitoring of antipsychotic medications and bruises by the CEC/designee by May 11, 2018. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The IDT will be in-served on the Comprehensive Care Plan Review including initiating care plans for side effect monitoring of antipsychotic medications and bruises by the CEC/designee by May 11, 2018. I added this · The IDT will review the Facility Activity Report daily in the clinical meeting to identify any bruises. The wound nurse will implement a care plan for residents with bruises the next business day after identification · All physician's orders will be reviewed daily in the clinical meeting by the IDT to identify any antipsychotic medications and ensure that a care plan is implemented for monitoring of side effects **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	were not limited to: fracture of unspecified part of neck of right femur. Resident 103 was admitted on 1/3/2018. The Admission Minimum Data Set (MDS), dated 1/10/2018, indicated Resident 103 was independent in decision making. A review of Resident 103's Admission Observation dated 1/3/2018, lacked documentation of resident having a bruise above the left eye. A review of Resident 103's Weekly Nursing Summary and Skin Assessment sheets lacked documentation of resident having a bruise above the left eye for the following dates: 1/9/2018 1/16/2018 1/23/2018 1/30/2018 2/6/2018 2/13/2018 2/20/2018 2/27/2018 3/6/2018 3/13/2018 3/20/2018 3/27/2018 4/3/2018 4/10/2018 A review of the current care plans for Resident 103 indicated there were no care plans or interventions in place for the healing bruise above the resident's left eye. During an interview, on 4/12/2018 at 10:54 a.m.,		**into place?** · Bruises and Unnecessary Medications QA Tool and will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	with the DON she did not deny there was no care plan for the healing bruise above Resident 103's left eye. On 4/7/2018 at 11:30 a.m., the DON provided the facility policy, "Comprehensive Care Plan Review" with a revised date of 1/2010, and indicated it was the policy currently being used by the facility. Review of the policy indicated, " ... the care plan will include measurable goals and resident specific interventions based on resident needs ... to promote the highest level of functioning including medical, nursing, mental, and psychosocial needs ..." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure staff identified and documented a bruise for 1 of 1 resident reviewed for a bruise. (Resident 103) Findings include: On 4/11/2018 at 9:29 a.m., Resident 103 was observed to have a healing, half dollar sized green and yellow bruise above her left eye. During an interview with the resident she indicated she	F 0684	**F684** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 103 no longer resides at the facility **How will you identify other residents having the potential**	05/11/2018

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	obtained the bruise in November of 2017, after a fall. During at interview, on 4/12/2018 at 2:58 p.m., Certified Nursing Assistant 1 (CNA) indicated she had assisted Resident 103 to bed and had not noticed a healing bruise above the resident's left eye. During at interview, on 4/12/2018 at 3:00 p.m., Licensed Practical Nurse 2 (LPN) indicated the healing bruise above Resident 103's left eye was old and was there when she admitted to the facility. During at interview, on 4/12/2018 at 10:54 a.m., the Director of Nursing (DON) indicated she talked to the son last night and he confirmed Resident 103 fell in November of 2017, and obtained the bruise above her left eye at that time. The DON indicated there should have been documentation of the bruise. Resident 103's clinical record was reviewed on 4/13/2018 at 10:50 a.m. Diagnoses included, but were not limited to: fracture of unspecified part of neck of right femur. Resident 103 was admitted on 1/3/2018. The Admission Minimum Data Set (MDS), dated 1/10/2018, indicated Resident 103 was independent in decision making. A review of Resident 103's Admission Observation dated 1/3/2018, lacked documentation of resident having a bruise above the left eye. A review of Resident 103's Weekly Nursing		**to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice · Facility wide skin sweep was conducted on 4/24/18 by nurse management team to identify and document any bruises · Nursing staff will be in-serviced by the CEC/designee on the Skin Management Policy by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All nursing staff will be in-serviced on the skin management policy by the CEC/designee by May 11, 2018 · The IDT will review the facility activity report including weekly skin assessments, admission assessments and shower sheets in the clinical meeting to identify any resident bruises · The wound nurse will complete a head to toe assessment on all new admissions the next business day to ensure that all bruising and areas of impaired skin integrity have been identified and documented in the clinical record · The DNS/designee will make rounds daily to observe for	

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	Summary and Skin Assessment sheets lacked documentation of resident having a bruise above the left eye for the following dates: 1/9/2018 1/16/2018 1/23/2018 1/30/2018 2/6/2018 2/13/2018 2/20/2018 2/27/2018 3/6/2018 3/13/2018 3/20/2018 3/27/2018 4/3/2018 4/10/2018 A review of the current care plans for Resident 103 indicated there were no care plans or interventions in place for the healing bruise above the resident's left eye. During an interview, on 4/12/2018 at 10:54 a.m., with the DON she did not deny there was no care plan for the healing bruise above Resident 103's left eye. On 4/13/2018 at 11:00 a.m., the DON provided the facility's policy, "Skin Management Program" with the current date of 4/2018, and indicated it was the policy currently being used by the facility. Review of the policy indicated, " ... PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY - PRESSURE AND NON-PRESSURE ... 3. All alterations in skin integrity will be documented on the admission observation in the medical record on the admission observation ... 5. b. The wound nurse will complete further evaluation of the		any resident bruising to ensure that it has been identified and documented in the clinical record · The Nurse management team will conduct skin sweeps monthly to ensure that all bruising has been identified and documented in the clinical record **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Bruises QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	wounds identified and complete the appropriate skin evaluation on the next business day ..." 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			

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	Based on interview and record review, the facility failed to ensure staff had competencies and skills to hold diltiazem (medication to treat high blood and chest pain caused by angina) for heart rate less than 80 for 1 of 5 residents reviewed for unnecessary medications. (Resident 100) Findings include: On 04/12/18 at 02:12 p.m., Resident 100's clinical record was reviewed. The diagnoses included, but not limited to, hypertension (HTN), chronic atrial fibrillation (A FIB), and chronic kidney disease. A review of Resident 100's physician orders, dated April 2018, indicated diltiazem 30 milligrams (mg) four times a day for A FIB (start date 3/2/18). Hold for heart rate less than 80. A review of Resident 100's Medication Administration Record (MAR) dated 3/1/18 through 4/16/18 lacked documentation of diltiazem 30 mg being held for heart rate less than 80 on the following days: -3/4/18 at 12:00 p.m., heart rate was 73, and medication was administered. by LPN 3. -3/5/18 at 12:00 p.m., heart rate was 76, and medication was administered by LPN 4. -3/8/18 at 4:00 p.m., heart rate was 75, and medication was administered by LPN 5. -3/8/18 at 8:00 p.m., heart rate was 72, and medication was administered by LPN 5. -3/12/18 at 8:00 a.m., heart rate was 76, and medication was administered by LPN 1. -3/25/18 at 4:00 p.m., heart rate was 72, and medication was administered by LPN 3. -3/31/18 at 8:00 p.m., heart rate was 78, and medication was administered by LPN 6. -4/1/18 at 8:00 p.m., heart rate was 77, and	F 0726	**F726** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 100 hold order was clarified and care plan was updated. Receives monitoring per physician order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with hold orders have the potential to be affected by the alleged deficient practice · An audit will be completed by May 11, 2018 to identify all residents with hold orders · Licensed nurses and QMAs will be in-serviced on medication administration policy including following hold orders by the CEC/designee by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed nurses and QMAs will be in-serviced on medication administration policy including following hold orders by the CEC/designee by May 11, 2018	05/11/2018

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	medication was administered by LPN 7. -4/2/18 at 8:00 a.m., heart rate was 68, and medication was administered by LPN 8. -4/2/18 at 12:00 p.m., heart rate was 68, and medication was administered by LPN 8. -4/3/18 at 4:00 p.m., heart rate was 77, and medication was administered by LPN 7 . -4/3/18 at 8:00 p.m., heart rate was 77, and medication was administered by LPN 7 . -4/6/18 at 4:00 p.m., heart rate was 78, and medication was administered by RN 1. -4/6/18 at 8:00 p.m., heart rate was 76, and medication was administered by RN 1. -4/8/18 at 8:00 p.m., heart rate was 73, and medication was administered by LPN 7. -4/13/18 at 4:00 p.m., heart rate was 68, and medication was administered by RN 1. -4/13/18 at 8:00 p.m., heart rate was 68, and medication was administered by RN 1. During an interview, on 04/16/18 at 11:27 a.m., LPN 1 indicated if pulse was less than 80, diltiazem was held. During an interview, on 04/16/18 at 12:39 p.m., the Director of Nurses (DON), reviewed Resident 100's March and April 2018 MARs, and indicated according to Resident 100's physician order diltiazem should have been held with a heart rate of less than 80 beats per minute. The "Nursing 2018 Drug Handbook", 38th edition, copyright 2018, indicated adverse reactions were arrhythmia (abnormal heart rate), bradycardia (slow heart rate), and hypotension (low blood pressure). The handbook indicated use cautiously in elderly patients and patients with impaired renal function. The nursing considerations were to monitor blood pressure and heart rate.		· Licensed nurses and QMAs will have a medication administration skills validation including following hold orders for medications by the CEC/designee by May 11, 2018 · DNS/designee will complete a MAR audit daily to ensure that all hold orders for mediations were followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Unnecessary Medications QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	On 4/18/18 at 11:00 a.m., the DON provided the "Charge Nurse Job Specific Orientaoin [sic]," undated, and indicated the policy was the one currently being used by the facility. A review of the policy indicated the policy did not address monitoring heart rate prior to cardiac medication administration.			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to follow physician order to hold diltiazem (medication to treat high blood and chest pain caused by angina) for heart rate less than 80 for 1 of 5 residents reviewed for unnecessary	F 0757	**F757** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	05/11/2018

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	medications. (Resident 100) Findings include: On 04/12/18 at 02:12 p.m., Resident 100's clinical record was reviewed. The diagnoses included, but not limited to, hypertension (HTN), chronic atrial fibrillation (A FIB), and chronic kidney disease. A review of Resident 100's physician orders, dated April 2018, indicated diltiazem 30 milligrams (mg) four times a day for A FIB (start date 3/2/18). Hold for heart rate less than 80. A review of Resident 100's Medication Administration Record (MAR) dated 3/1/18 through 4/16/18 lacked documentation of diltiazem 30 mg being held for heart rate less than 80 on the following days: -3/4/18 at 12:00 p.m., heart rate was 73, and medication was administered. -3/5/18 at 12:00 p.m., heart rate was 76, and medication was administered. -3/8/18 at 4:00 p.m., heart rate was 75, and medication was administered. -3/8/18 at 8:00 p.m., heart rate was 72, and medication was administered. -3/12/18 at 8:00 a.m., heart rate was 76, and medication was administered. -3/25/18 at 4:00 p.m., heart rate was 72, and medication was administered. -3/31/18 at 8:00 p.m., heart rate was 78, and medication was administered. -4/1/18 at 8:00 p.m., heart rate was 77, and medication was administered. -4/2/18 at 8:00 a.m., heart rate was 68, and medication was administered. -4/2/18 at 12:00 p.m., heart rate was 68, and medication was administered.		**practice?** ·Resident 100 hold order was clarified and care plan was updated. Receives monitoring per physician order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents with hold orders have the potential to be affected by the alleged deficient practice ·An audit will be completed by May 11, 2018 to identify all residents with hold orders ·Licensed nurses and QMAs will be in-serviced on medication administration policy including following hold orders by the CEC/designee by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Licensed nurses and QMAs will be in-serviced on medication administration policy including following hold orders by the CEC/designee by May 11, 2018 ·Licensed nurses and QMAs will have a medication administration skills validation including following hold orders for medications by the CEC/designee by May 11, 2018 ·DNS/designee will complete a MAR audit daily to ensure that all hold orders for mediations were followed.	

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	-4/3/18 at 4:00 p.m., heart rate was 77, and medication was administered. -4/3/18 at 8:00 p.m., heart rate was 77, and medication was administered. -4/6/18 at 4:00 p.m., heart rate was 78, and medication was administered. -4/6/18 at 8:00 p.m., heart rate was 76, and medication was administered. -4/8/18 at 8:00 p.m., heart rate was 73, and medication was administered. -4/13/18 at 4:00 p.m., heart rate was 68, and medication was administered. -4/13/18 at 8:00 p.m., heart rate was 68, and medication was administered. During an interview, on 04/16/18 at 11:27 a.m., LPN 1 indicated if pulse was less than 80, diltiazem was held. During an interview, on 04/16/18 at 12:39 p.m., the Director of Nurses (DON), reviewed Resident 100's March and April 2018 MARs, and indicated according to Resident 100's physician order diltiazem should have been held with a heart rate of less than 80 beats per minute. The "Nursing 2018 Drug Handbook", 38th edition, copyright 2018, indicated adverse reactions were arrhythmia (abnormal heart rate), bradycardia (slow heart rate), and hypotension (low blood pressure). The handbook indicated use cautiously in elderly patients and patients with impaired renal function. The nursing considerations were to monitor blood pressure and heart rate. On 4/16/18 at 3:57 p.m., the DON provided the "Medication Pass Procedure" policy, dated 12/2016, and indicated the policy was the one currently being used by the facility. A review of		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Unnecessary Medications QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	the policy indicated the policy did not address monitoring heart rate prior to cardiac medication administration. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			

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	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure side effects of an antipsychotic medication were monitored for 1 of 5 residents reviewed for unnecessary medications (Resident 51). Findings include: On 4/12/18 at 1:00 P.M., Resident 51's clinical record was reviewed. Diagnoses included, but not limited to, Parkinson's disease and unspecified dementia with behavioral disturbance. April 2018 Physician's order, with a start date of 3/16/18, for Seroquel (an antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder), 25 mg twice daily. The clinical record indicated the medication was current, and the resident was receiving the medication as ordered.	F 0758	**F758** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 51 had a care plan in place for “psychotropic” medication side effects, initiated 9/23/16. The care plan was updated to add “antipsychotic” side effects · Resident 51 with new order to monitor for antipsychotic side effects **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents receiving antipsychotic medication have the potential to be affected by the	05/11/2018

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	There was no indication the potential side effects of Seroquel, which include constipation, dizziness, drowsiness, headache, increased serum cholesterol, increased serum triglycerides, increased thyroid stimulating hormone level, abdominal pain, orthostatic hypotension, pharyngitis, weight gain, and tachycardia (2014 Nursing Drug Handbook), were being monitored. During an interview, on 4/12/18 at 3:45 P.M., the Director of Nursing indicated there was no side effects monitoring of the Seroquel in place as there should have been, and this would be added to the resident's clinical record. On 4/17/18 at 11:30 A.M., the Director of Nursing provided the facility's policy, "Psychotropic Management", revised date of 9/17, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "....potential adverse side effects to psychotropic medications will be monitored each shift by a licensed nurse..." 3.1-48(a)(3)		alleged deficient practice · An audit of all residents on psychotropic medication will be done by May 11, 2018 to ensure that there is an order for side effect monitoring in the Medication Administration Record. · Medical Records will be in-serviced by DNS/designee related to ensuring all residents receiving antipsychotics have a monitoring order in place in EMAR by May 11, 2018 · Licensed nurses will be in-serviced on the Psychotropic Medication policy including side effect monitoring for resident's on antipsychotic medication by May 11, 2018 by the CEC/designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All physician's orders will be reviewed daily in the clinical meeting by the IDT to identify any antipsychotic medications and ensure that a physician's order for monitoring of side effects is present · The DNS/designee will complete a MAR audit daily to ensure that side effects of antipsychotic medication are being monitored through the EMAR compliance report · Licensed nurse will be in-serviced on the Psychotropic	

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			Medication policy including side effect monitoring for resident's on antipsychotic medication by May 11, 2018 by the CEC/designee · Medical Records will be in-serviced by DNS/designee related to ensuring all residents receiving antipsychotics have a monitoring order in place in EMAR by May 11, 2018 . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Unnecessary Medication QA Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;			

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	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was served at a palatable temperature for 6 of 32 residents interviewed regarding food quality (Resident 214, Resident 313, Resident 111, Resident 83, Resident 105, Resident 215), for 8 of 8 members who attend resident council meetings (Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 8, Resident 38) and for 3 of 3 residents reviewed for grievances (Resident 75, Resident 91, Resident 28). Findings include: a.) During an interview, on 4/10/2018 at 3:35 p.m., Resident 214 indicated the food is always served cold. During an interview, on 4/11/2018 at 9:55 a.m., Resident 313 indicated her food is always served cold. During an interview, on 4/11/2018 at 1:55 p.m., Resident 111 indicated her food is always served cold. During an interview, on 4/12/2018 at 9:34 a.m., Resident 83 indicated the food is often served cold. During an interview, on 4/12/2018 at 9:45 a.m., Resident 105 indicated the food is often served cold. During an interview, on 4/12/2018 at 10:26 a.m., Resident 215 indicated the food is always served	F 0804	**F804** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 214 receives food at appropriate temperatures · Resident 313 receives food at appropriate temperatures · Resident 111 receives food at appropriate temperatures · Resident 83 receives food at appropriate temperatures · Resident 105 receives food at appropriate temperatures · Resident 215 receives food at appropriate temperatures · Resident 25 receives food at appropriate temperatures · Resident 72 receives food at appropriate temperatures · Resident 107 receives food at appropriate temperatures · Resident 28 receives food at appropriate temperatures · Resident 109 receives food at appropriate temperatures · Resident 70 receives food at appropriate temperatures · Resident 8 receives food at appropriate temperatures · Resident 38 receives food at appropriate temperatures · Resident 75 receives food at appropriate temperatures	05/11/2018

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	cold. b.) During the Resident Council meeting on, 4/13/2018 at 10:26 a.m., the council members indicated the food is often served cold. They have complained about it for a few weeks but, the facility had not done anything to correct the situation. Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 8, and Resident 38 were present at the meeting. Review, on 4/16/2018 at 4:00 p.m., of the Resident Council Meeting Minutes indicated the following: On 3/5/2018 at 3:00 p.m., the Resident Council concerns were, food not hot. There were 7 residents in attendance at the meeting. (Resident 25, Resident 72, Resident 107, Resident 109, Resident 70, Resident 8, Resident 85). The Resident Council minutes log lacked documentation of follow up for the Resident Council meeting on 3/5/2018, in regard to food not being served hot. On 3/19/2018 at 3:15 p.m., the Resident Council concerns were, food not hot. There were 8 residents in attendance at the meeting. (Resident 25, Resident 72, Resident 107, Resident 28, Resident 109, Resident 70, Resident 76, and one resident who no longer resides at the facility). A review of the Resident Council Meeting Follow up, dated 3/20/18, for the Resident Council meeting on 3/19/2018, indicated: food temped (temperature) before and during each meals and logged. The form was signed by the department manager. Interview with residents at the Resident Council meeting on 4/13/2018 at 10:26 a.m., indicated the food continues to be served cold		· Resident 91 receives food at appropriate temperatures **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice · Residents 214, 313, 111, 83, 105, 215, 25, 72, 107, 28, 109, 70, 8, 38, 75, and 91 were invited to Resident Food Council on 4/30/18 or to meet with Certified Dietary Manager/designee if unable to attend · Call placed by Maintenance Director on 4/20/18 to service the Dinex base warmer · Steam table and plate warmer assessed and are in working order · Dietary staff will be in-serviced by CDM on the food temperature policy including proper food temperatures, serving meals and taking food temperatures by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Dietary staff will be in-serviced by CDM on the food temperature policy including proper food temperatures, serving	

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	and they feel staff have not responded to their concerns. c. On 4/16/2018 at 4:01 p.m., the DON provided copies of Concern/Grievance forms. The forms indicated the following: On 3/13/2018 at 1:16 p.m., Resident 75 indicated her soup was cold. A follow up with the department head on 3/20/2018, indicated, " ...plate warmer and steam table working properly and at right temps (temperature). Staff educated on checking temps of food regularly and filling out log ..." On 3/20/2018 at 5:00 p.m., Resident 91 indicated food temps are a concern. A follow up with the department head on 3/22/2018, indicated, " ... temping food during cooking process and before service ..." On 4/4/2018 at 1:30 p.m., Resident 28 indicated food is served cold. A follow up with the department head on 4/4/2018, indicated, " ... temping food to make sure the food is hot ..." During an interview, on 4/17/2018 at 1:00 p.m., with the Administrator, she indicated the facility had gone through a change with dietary staff but things are starting to get better. On 4/18/2018 at 10:57 a.m., the Director of Nursing provided the facility's policy, "Food Temperatures" with the current date of 11/17, and indicated it was the policy currently being used by the facility. Review of the policy indicated, " ... 2. All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food ..."		meals and taking food temperatures by May 11, 2018 · CDM will hold weekly educational meetings with dietary staff weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 4 months to provide further education and update dietary staff on resident's concerns and requests · CDM will hold Resident Food Council meetings weekly x 4 weeks, bi-weekly x 4 weeks, then monthly thereafter · CDM/designee will audit test tray 5 times a week in alternating areas x 30 days, 3 times a week x 30 days, 2 times a week x 30 days, then weekly x 90 days **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Meal Observation Trayline Observation QA Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	3.1-21(a)(2)			
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 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 staff disposed of inedible food, maintained the kitchen floors in a sanitary manner, and utilized a hand washing sink for 1 of 1 kitchen. This had the potential to effect 112 of 112 residents who are served from the kitchen. Findings include: 1.) During an initial tour of the kitchen, on 4/10/18 at 11:00 a.m., with the dietary manager (DM)	F 0812	**F 812** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The inedible food was disposed of · The kitchen floor has been cleaned and sanitized · Cook 1 washes hands per	05/11/2018

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	present, the following was observed: a.) The kitchen floor in the cooking area, dry food storage area, and dish washing area, were covered in various stains, crumbs, and food substances. The DM indicated she will have staff mop the floors. b.) A large box of romaine lettuce was observed to be covered with mold. The DM was observed to removed the box from the refrigerator and indicate it needed to be thrown out. c.) A large red stain was observed in the freezer with a frozen hamburger patty on top. The DM indicated the stain was from cranberries and she was observed to remove the hamburger patty from the floor and throw it away. On 4/17/18 at 11:44 a.m., the Administrator provided the facility policy, "Food Storage," revised November, 2017, and indicated it was the policy currently being used. A review of the policy indicated, "....storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared and transported ... by methods designed to prevent contamination..." 2.) During a subsequent visit to the kitchen, on 4/18/18 at 10:45 a.m., Cook 1 was observed to walk to the hand washing sink, apply soap to hands, and walk around the kitchen stove and counters while lathering hands. On 4/17/18 at 11:47 a.m., the Director of Nursing provided the facility policy, "Hand Washing in the Kitchen," updated on January, 2016, and indicated it was the policy currently being used. A review of the policy did not address the need for staff to stay at the hand washing sink during the		policy at the handwashing sink **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice · CDM/designee will conduct a Sanitation Audit by May 11, 2018 · Dietary employees will be in-serviced on utilizing the hand washing sink on May 11, 2018 · Kitchen floors were deep cleaning on May 2, 2018 · Dietary employees will be in-serviced on the Food Safety, Food Storage, Handwashing in the Kitchen, and Cleaning Floors, tables and chairs policies by the CDM by May 11, 2018 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Dietary employees will be in-serviced on the Food Safety, Food Storage, Handwashing in the Kitchen, and Cleaning Floors, tables and chairs policies by the CDM by May 11, 2018 · CDM will conduct Sanitation Audits daily x 30 days, weekly x 30 days, bi-weekly x 60 days and monthly thereafter · Kitchen floors will be deep	

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	hand washing procedure. On 4/19/17 at 10:00 a.m., a review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, "... Where to wash hands ... Sec. 130. (a) Food employees shall clean their hands in a hand washing sink or approved automatic hand washing facility ..." 3.1-21(i)(2) 3.1-21(i)(3)		cleaned on the 1st Wednesday of each month · Dietary staff will be in-serviced on Hand Washing, including remaining at sink while washing hands, by CDM/designee by May 1, 2018 · Dietary staff will be in-serviced on facility's cleaning schedule, sanitation, and food storage by CDM/designee by May 1, 2018 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Food Storage, Proper Hand Washing QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 10, 11, 12, 13, 16, 17, and 18,	R 0000	**This plan of correction constitutes this facility' s written allegation of compliance for the deficiencies cited. The submission of this**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOW LAKES	200 MEADOW LAKE DR MOORESVILLE, IN 46158

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	2018 Facility number: 004831 Residential Census: 49 Meadow Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review completed on April 24, 2018.		**plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Meadow Lakes is respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.**	