STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00256240. Complaint IN00256240 - Substantiated. Federal/state deficiencies related to the allegations are cited at F656, F660, F661, F745 and F842. Survey dates: July 2 and 3, 2018 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 88 SNF: 10 Total: 98 Census Payor Type: Medicare: 12 Medicaid: 66 Other: 20 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 10, 2018	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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

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	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 care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to ensure a care plan was developed for	F 0656	**(Tag F 656) Develop/Implement Comprehensive Care plans:**	08/02/2018

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	discharge planning related to return to the community for 1 of 3 residents reviewed for discharge planning. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7-2-18 at 11:24 a.m. His admission Minimum Data Set (MDS) assessment, dated 1-25-18, indicated he expected to return home, but no discharge planning activities had been initiated at that time. The same MDS assessment indicated he was cognitively intact. His discharge date was listed as 3-31-18. Review of the clinical record indicated a lack of a care plan development related to discharge planning for Resident B had been conducted during his stay at the facility. In an interview with the Executive Director on 7-2-18 at 4:09 p.m., she indicated the facility had a new Social Services Director (SSD) at the time of Resident B's stay. She shared the SSD "was having a hard time with documentation and things like that...It was a planned discharge [for Resident B]. Therapy was working with him and Social Services in order to get him ready to go home. It looks like the Social Services did not get much documentation completed on his discharge." In an interview with the MDS Coordinator on 7-3-18 at 12:54 p.m., she indicated the facility staff were unable to locate a care plan for Resident B's discharge planning. This Federal tag relates to Complaint IN00256240. 3.1-35(a)		It is the practice of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with the potential to return to the community have the potential to be affected by the alleged deficient practice. A facility audit will be conducted by the Care Plan Team. This audit will include review of all resident care plans. This will ensure that all needed and required care plans are in place. Care plans will be initiated if indicated, reviewed and updated to reflect each resident's status including discharge	

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			planning. Care plans are reviewed/initiated and updated by IDT/Nurse Management Team at the time of admission/re-admission, quarterly, annually and with any change in condition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Interdisciplinary Care Plan team and nursing staff in-service will be conducted on or before 08/02/18. This in-service will include review of the facility policy related to development and implementation of person-centered care plans for each resident including discharge planning. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans as outlined in the comprehensive assessment. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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			Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to Care Plan Review weekly for 4 weeks and monthly for 3 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what Date the systemic changes for each deficiency will be completed.** August 2, 2018	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these			

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	changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient			

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	assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on interview and record review, the facility failed to ensure discharge planning activities were conducted and documented for 1 of 3 residents reviewed for discharge planning. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7-2-18 at 11:24 a.m. His admission Minimum Data Set (MDS) assessment, dated 1-25-18, indicated he expected to return home, but no discharge planning activities had been initiated at that time. The same MDS assessment indicated he was cognitively intact. His discharge date was listed as 3-31-18. Review of the multi-disciplinary progress notes detailed limited documentation by the Social Services Designee (SSD) regarding discharge planning. In the month of March, 2018, the SSD documented two notes in the progress notes. A	F 0660	**(Tag F 660) Discharge Planning Process** It is the policy of this facility to provide ongoing evaluation and discharge planning for all appropriate residents while in the facility. Appropriate IDT members will assist in discharge plan formulation, education, and discharge preparation with the resident and responsible party. It is the policy of this facility that residents will discharge from the facility, as per physician's order, and that a review of the resident's home care needs and medications are completed with the resident and family prior to discharge from the facility.	08/02/2018

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	notation, dated 3-6-18, indicated she had discussed a situation with Resident B, addressing him being observed smoking on the premises. "Resident requested to be assessed by [name of an area nursing home] as resident are [sic] allowed to smoke there at certain times. SS left a message with resident family member regarding resident wanting to be transferred to a smoking SNF." A second note, dated, 3-8-18: "MCSS spoke to resident to inform him that discharge planning was taking place as he continues to be non-adherent to care. Resident elected to discharge to home on [local address] and refused home care. Resident's contact she said will assist him in getting him his medications." In an interview with the Executive Director on 7-2-18 at 4:09 p.m., she indicated the facility had a new Social Services Director (SSD) at the time of Resident B's stay. She shared the SSD "was having a hard time with documentation and things like that...It was a planned discharge [for Resident B]. Therapy was working with him and Social Services in order to get him ready to go home. It looks like the Social Services did not get much documentation completed on his discharge." In an interview with the MDS (Minimum Data Set assessment) Coordinator on 7-3-18 at 12:54 p.m., she indicated the facility staff were unable to locate a care plan for Resident B's discharge planning. On 7-3-18 at 12:25 p.m., the MDS Coordinator provided a copy of a policy entitled, "Discharge Planning," with a revision date of October, 2017. This policy indicated, "It is the policy of this [sic] to implement an effective, interdisciplinary discharge planning process that focuses on the resident's discharge goals, the preparation of		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with the potential to return to the community have the potential to be affected by the alleged deficient practice. An audit of discharge / transfers for the last 30 days will be conducted by the DNS / designee to ensure accuracy of discharge instructions and accurate and complete resident and family education. The audit will include Physician ordered discharge medications and instructions as well as any needed DME. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A nursing in-service to review Discharge Policy and process will be conducted by the DNS or designee on or before 08/02/18. Resident and family discharge	

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	residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Discharge planning will include an ongoing person-centered evaluation of needs, caregiver support, goals and preferences...Upon admission, social services will assist in identifying resident's discharge planning goal and initiate appropriate discharge planning...Residents that are appropriate for discharge planning will have collaboration with desired representative/caregivers or other support persons as applicable, and appropriate IDT members for a discharge plan formulation. Appropriate referrals for home health care, obtaining medications, equipments, treatments will be made as indicated by the physician. Education and teaching identified as needed (i.e., wound care, specialized diets, etc.) will be given to resident/representative or support person and documented in the medical record..." This Federal tag relates to Complaint IN00256240. 3-1-12(a)(18) 3-1-12(a)(19) 3-1-12(a)(20) 3-1-12(a)(21) 3-1-12(a)(23)		education will be completed before discharge. All resident Discharges Instructions from the facility will be reviewed by the IDT team to ensure complete and accurate. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to discharges weekly for 4 weeks and monthly for 3 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what Date the systemic changes for each deficiency will be completed.** August 2, 2018	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary			

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	that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on interview and record review, the facility failed to ensure the written discharge summary and information form was completed for 1 of 3 residents reviewed for discharge planning. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7-2-18 at 11:24 a.m. His admission Minimum Data Set (MDS) assessment, dated 1-25-18, indicated he expected to return home. The same MDS	F 0661	**(Tag F 661) Discharge Summary** It is the practice of this provider that residents will discharge from the facility, as per Physician's order, and that a discharge summary is complete. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/02/2018

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	assessment indicated he was cognitively intact. His discharge date was listed as 3-31-18. Review of the facility's "Discharge/Appointment/Transfer -- ASC Home Discharge Instructions and Information" form for Resident B indicated a significant lack of completion of the form. The form was initiated on 3-26-18, with completion date of 3-31-18. The form was missing the following information: -the resident's community physician or contact information or suggested next appointment. -the resident's identified allergies, skin conditions, nursing special instructions, any special equipment required. -a recap of the resident's stay at the facility, including admission diagnoses, pertinent findings, summary of treatment course and condition upon discharge. -listing of home medications and treatment orders, including the name of the medication or treatment, dose, frequency, reason for use, time of last administration and for any medications or treatments sent with the resident, the amounts of each and prescription numbers. -any dietary orders or recommendations. -any therapy orders or recommendations. -identification of the current activity level of the resident. -any vital signs obtained at the time of discharge. -any signatures of the facility staff or the resident to attest the resident received and/or comprehended any discharge instructions provided to the resident at the time of discharge, nor that the resident received a copy of the document. On 7-3-18 at 12:25 p.m., the MDS Coordinator provided a copy of a policy entitled, "Discharge Planning," with a revision date of October, 2017.		**practice.** Resident no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with the potential to return to the community have the potential to be affected by the alleged deficient practice. An audit of discharges/transfers for the last 30 days will be conducted by DNS or designee to ensure completion of discharge summaries. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A nursing in-service to review the Discharge Policy and process to include discharge summary will be conducted by the DNS or designee on or before 08/02/18. Discharge teaching will also be documented in the appropriate discipline's progress notes. Nursing will complete the medication portion of the Home Discharge Instructions form and ensure that the resident has an adequate supply of medications in accordance with state regulations and/or physicians order. Resident/responsible party will	

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	This policy indicated, "It is the policy of this [sic] to implement an effective, interdisciplinary discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Discharge planning will include an ongoing person-centered evaluation of needs, caregiver support, goals and preferences...Upon admission, social services will assist in identifying resident's discharge planning goal and initiate appropriate discharge planning...Residents that are appropriate for discharge planning will have collaboration with desired representative/caregivers or other support persons as applicable, and appropriate IDT members for a discharge plan formulation. Appropriate referrals for home health care, obtaining medications, equipments, treatments will be made as indicated by the physician. Education and teaching identified as needed (i.e., wound care, specialized diets, etc.) will be given to resident/representative or support person and documented in the medical record...For discharges with a physician's order to home: Home discharge instructions will be completed by the IDT including medication list and follow up appointments as scheduled. The Home Discharge Instructions will be reviewed and signed by the resident/representative in a manner they are able to understand; a copy of the Home Discharge Instructions will be given to the resident/representative." This Federal tag relates to Complaint IN00256240. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3)		sign the discharge form acknowledging understanding of the discharge instructions, including medication administration. Medication administration should be written in lay terms. Social Service will initiate contact with a home health agency to ensure continuity of care and will coordinate equipment delivery to the resident's home as deemed appropriate by the discharge plans. Social Service will assist arranging special transportation if required. Administrator/DNS/Designee will review all open discharges daily during morning clinical meeting to ensure all areas of discharge summary form have been completed before discharge of resident. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance with this corrective action, the DNS/designee will complete the CQI tool titled, “Discharge Planning”. This tool will be completed weekly for 4 weeks followed by monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee	

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	3.1-36(b)		for review and follow up. **By what Date the systemic changes for each deficiency will be completed.** August 2, 2018	
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure the services of the Social Services Designee were appropriate to meet the discharge planning needs for 1 of 3 residents reviewed for discharge planning. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7-2-18 at 11:24 a.m. His admission Minimum Data Set (MDS) assessment, dated 1-25-18, indicated he expected to return home, but no discharge planning activities had been initiated at that time. The same MDS assessment indicated he was cognitively intact. His discharge date was listed as 3-31-18. Review of the clinical record indicated a lack of documentation related to care plan development specific to discharge planning for Resident B, for care plan development and documentation in general of the status of progression toward discharge. In an interview with the MDS (Minimum Data Set assessment) Coordinator on 7-3-18 at 12:54 p.m.,	F 0745	**(Tag F 745)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident found to have been affected by the deficient practice was discharged to the community and is no longer residing at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with the potential to return to the community have the potential to be affected by the alleged deficient practice. All resident with preferences to return to the community care plans will be audited for completion and to ensure discharge activities are occurring.	08/02/2018

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	155230	A. BUILDING 00 B. WING	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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	she indicated the facility staff were unable to locate a care plan for Resident B's discharge planning. In an interview with the Executive Director on 7-2-18 at 4:09 p.m., she indicated the facility had a new Social Services Director (SSD) at the time of Resident B's stay. She shared the SSD "was having a hard time with documentation and things like that...It was a planned discharge [for Resident B]. Therapy was working with him and Social Services in order to get him ready to go home. It looks like the Social Services did not get much documentation completed on his discharge." In an interview with the Executive Director on 7-3-18 at 11:25 a.m., she indicated the facility had some issues with the SSD at the time of Resident B's stay and discharge. "She was new to long-term care." In an interview with the Executive Director on 7-3-18 at 2:15 p.m., she specified the SSD was hired on 10-4-2017, and is no longer employed at the facility, effective 5-15-2018. This Federal tag relates to Complaint IN00256240. 3.1-34(a)(1) 3.1-34(a)(2)		Review of the last 30 days of discharges to the community will be audited to ensure that home discharge instructions were completed. If incomplete, instructions will be mailed to resident/representative. New SSD was educated by SS Consultant on 7/2/18 and 7/3/18 regarding policy and procedures associated with discharge planning. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** New SSD, hired 6/12/18, was educated by SS Consultant on 7/2/18 and 7/3/18 regarding policy and procedures associated with discharge planning. SS Consultant will be notified of discharges to home weekly for review x 4 weeks. SSD will attend, at minimum one offsite Social Service Discharge Training offered by SS Consultant(s) for additional education purposes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** The Discharge Planning QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results	

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			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 **By what date the systemic changes will be completed;** August 2, 2018	
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident			

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	representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and			

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	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure the inventory record of the resident's personal belongings was completed upon entrance and upon the resident's discharge from the facility for 1 of 3 residents reviewed for discharge. Findings include: The clinical record of Resident B was reviewed on 7-2-18 at 11:24 a.m. His admission date was listed as 1-18-18. His discharge date was listed as 3-31-18. An "Inventory of Personal Belongings" form for Resident B indicated the listed items were inventoried on 3-2-18 by a staff member. The document was not dated or signed by facility staff or the resident for the "Admission" portion or the discharge portion of the document. A handwritten notation was located on the facility's "Discharge/Appointment/Transfer -- ASC Home Discharge Instructions and Information" form for Resident B, dated 3-31-18 at 5:45 p.m., stating, "Res[ident] taking all personal belongings with him." It was signed by Resident B, but was unsigned by facility staff. The notation did not specify what items were taken by Resident B. On 7-3-18 at 12:25 p.m., the MDS Coordinator provided a copy of a policy entitled, "Discharge Planning," with a revision date of October, 2017. This policy indicated, "The inventory of the resident's personal belongings should be reviewed and signed by staff and resident/responsible party." This Federal tag relates to Complaint IN00256240.	F 0842	**(Tag F 842) Resident Records-Identifiable Information** It is the practice of this facility to complete and maintain inventory records of resident's personal belongings upon admission and discharge from the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with the potential to return to the community have the potential to be affected by the alleged deficient practice. An audit of admissions / discharges/transfers for the last 30 days will be conducted by DNS or designee to ensure completion of inventory records. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	08/02/2018

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	3.1-50(a)(1) 3.1-50(a)(2)		A nursing in-service to review admit / discharge to include resident inventory process will be conducted by the DNS / designee by 08/02/18. IDT will review new admissions / discharges to ensure inventory records are complete. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance with this corrective action, the DNS/designee will complete the CQI tool titled, "Discharge Planning." This tool will be completed weekly for 4 weeks followed by monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what Date the systemic changes for each deficiency will be completed.** August 2, 2018	