CENTERS FOI	R MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230		(X2) MULTIPLE CON A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/03/2018
	PROVIDER OR SUPPLIER JD VILLAGE	2050 CH	DDRESS, CITY, STATE, ZIP COD ESTER BLVD DND, IN 47374	
(VA) ID	GUN O (A DV GE A TIEN EN VE OF DEFICIENTALE		· · · · · · · · · · · · · · · · · · ·	975
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE
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.		This Plan of Correction constit my written allegation of compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and feder law. This provider respectfully require that the 2567 Plan of Correction be considered the letter of creallegation and requests a desireview in lieu of a Post Compl Survey Revisit on or after.	s if this cists ts ral lests on dible k
F 0656 SS=D Bldg. 00	Quality review completed on July 10, 2018 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

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED		ETED	
		155230	B. W	B. WING 07/03/201			2018
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			HESTER BLVD		
ROSFRI	JD VILLAGE				OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
), that includes measurable					
	1	neframes to meet a					
		I, nursing, and mental and					
	comprehensive as	ds that are identified in the					
		are plan must describe the					
	following -	are plan must describe the					
	•	nat are to be furnished to					
		the resident's highest					
	practicable physic	•					
	1 ' ' '	-being as required under					
	§483.24, §483.25 or §483.40; and						
	(ii) Any services that would otherwise be						
	required under §4	83.24, §483.25 or §483.40					
	but are not provid	ed due to the resident's					
	exercise of rights	under §483.10, including					
	the right to refuse	treatment under §483.10(c)					
	(6).						
	(iii) Any specialize	ed services or specialized					
		ices the nursing facility will					
	provide as a resul						
		s. If a facility disagrees with					
	•	PASARR, it must indicate					
		resident's medical record.					
	1 1	with the resident and the					
	resident's represe	• ,					
		goals for admission and					
	desired outcomes	preference and potential for					
	1 ' '	Facilities must document					
	•	ent's desire to return to the					
		ssessed and any referrals					
		gencies and/or other					
		es, for this purpose.					
		ns in the comprehensive					
		ropriate, in accordance with					
		set forth in paragraph (c) of					
	this section.						
	1	and record review, the facility	F 0	656	(Tag F 656) Develop/Impleme	ent	08/02/2018
		are plan was developed for			Comprehensive Care plans:		

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07/30/2018 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/03/2018 155230 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD **ROSEBUD VILLAGE** RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE discharge planning related to return to the community for 1 of 3 residents reviewed for It is the practice of this facility to discharge planning. (Resident B) develop and implement a comprehensive person-centered Findings include: care plan for each resident. consistent with the resident rights The clinical record of Resident B was reviewed on set forth that includes measurable 7-2-18 at 11:24 a.m. His admission Minimum Data objectives and timeframes to meet Set (MDS) assessment, dated 1-25-18, indicated a resident's medical, nursing, and he expected to return home, but no discharge mental and psychological needs planning activities had been initiated at that time. that are identified in the The same MDS assessment indicated he was comprehensive assessment. cognitively intact. His discharge date was listed as 3-31-18. What corrective action(s) will be accomplished for those Review of the clinical record indicated a lack of a residents found to have been care plan development related to discharge affected by the deficient planning for Resident B had been conducted practice. during his stay at the facility. Resident no longer resides at the In an interview with the Executive Director on facility. 7-2-18 at 4:09 p.m., she indicated the facility had a new Social Services Director (SSD) at the time of How other residents having the Resident B's stay. She shared the SSD "was potential to be affected by the having a hard time with documentation and things same deficient practice will be like that...It was a planned discharge [for Resident identified and what corrective B]. Therapy was working with him and Social actions will be taken? Services in order to get him ready to go home. It All residents with the potential to looks like the Social Services did not get much return to the community have the documentation completed on his discharge." potential to be affected by the alleged deficient practice. A In an interview with the MDS Coordinator on facility audit will be conducted by 7-3-18 at 12:54 p.m., she indicated the facility staff the Care Plan Team. This audit were unable to locate a care plan for Resident B's will include review of all resident discharge planning. care plans. This will ensure that all needed and required care plans

3.1-35(a)

This Federal tag relates to Complaint IN00256240.

LM7O11

are in place. Care plans will be initiated if indicated, reviewed and

updated to reflect each resident's status including discharge

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/03/2018	
	ROVIDER OR SUPPLIER D VILLAGE		2050 C	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				planning. Care plans are reviewed/initiated and update IDT/Nurse Management Tear the time of admission/re-admission, quar annually and with any change condition.	n at terly,
				What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The Interdisciplinary Care Plateam and nursing staff in-service will be conducted on or before 08/02/18. This in-service will include review of the facility prelated to development and implementation of person-cencare plans for each resident including discharge planning. nursing staff will be re-educat the process of reviewing, upd and following all resident care plans as outlined in the comprehensive assessment.	n rice e olicy stered All ed on ating
				How will the corrective action be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Ongoing compliance with this corrective action will be monit through the facility Quality Assurance and Performance	out

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 155230 B. WING				(X3) DATE SURVEY COMPLETED 07/03/2018		
	PROVIDER OR SUPPLIEI	?		2050 C	ADDRESS, CITY, STATE, ZIP COD HESTER BLVD IOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0660 SS=D Bldg. 00	The facility must of effective discharge focuses on the rest the preparation of partners and effect post-discharge can factors leading to The facility's discharge to must be consister set forth at 483.15				Improvement Program. The DNS/Designee will be respons for completing the QAPI Audit related to Care Plan Review weekly for 4 weeks and month for 3 months. If threshold of 9 is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for reand follow-up. By what Date the systemic changes for each deficiency will be completed. August 2, 2018	tool nly 0% be	

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resident.

resident are identified and result in the development of a discharge plan for each

(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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		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/03/2018	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				2050 CH	DDRESS, CITY, STATE, ZIP COD HESTER BLVD OND, IN 47374			
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	(X5) COMPLETION
	TAG	changes. (iii) Involve the intitle defined by §483.2 process of develo (iv) Consider care availability and the caregiver's/suppo capability to perform the identification of (v) Involve the reserversentative in the identification of (v) Involve the reserversentative in the discharge plan and resident represent (vi) Address the restreatment preferent (vii) Document the asked about their information regard community. (A) If the resident returning to the conduction of the condu	rt person(s) capacity and rm required care, as part of of discharge needs. ident and resident the development of the dinform the resident and tative of the final plan. esident's goals of care and nees. at a resident has been interest in receiving ding returning to the indicates an interest in ommunity, the facility must errals to local contact appropriate entities made are plan and discharge plan, response to information errals to local contact appropriate entities. The community is be feasible, the facility ho made the determination who are transferred to the are discharged to a H, assist residents and esentatives in selecting a rovider by using data that of limited to SNF, HHA,		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2018				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	and data on resoud data is available. It that the post-acute assessment data, and data on resoud applicable to the resource treatment preferer (ix) Document, coubased on the resident's discharge plan. The results of discussed with the representative. All information must be discharge plan to and to avoid unner resident's discharge plan to an avoid unner resident's discharge plan to an avoid unner resident's discharge plan to an avoid unner resident's discharge planning activities in the same MDS assessmine expected to return planning activities in the same MDS assessmine assessment data and the resident in the same MDS assessminer than a same manual resident in the same man	mplete on a timely basis dent's needs, and include in the evaluation of the ge needs and discharge of the evaluation must be e resident or resident's relevant resident be incorporated into the facilitate its implementation cessary delays in the	F 0660	(Tag F 660) Discharge Plann Process It is the policy of this facility to provide ongoing evaluation and discharge planning for all appropriate residents while in facility. Appropriate IDT memi will assist in discharge plan formulation, education, and discharge preparation with the resident and responsible part is the policy of this facility that residents will discharge from facility, as per physician's ord and that a review of the reside home care needs and medicate completed with the reside and family prior to discharge the facility.	the bers ey. It the the er, ent's entions nt		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED	
		155230	B. W	ING		07/03	3/2018
NAME OF I	PROVIDER OR SUPPLIE	D.	•	STREET	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	-ROVIDER OR SUFFLIE	K		2050 C	CHESTER BLVD		
ROSEBUD VILLAGE				RICHM	MOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		-18, indicated she had					
		on with Resident B, addressing			What corrective action(s) w	/ill	
	_	d smoking on the premises.			be accomplished for those		
	_	d to be assessed by [name of			residents found to have be	en	
	_	me] as resident are [sic] allowed			affected by the deficient		
		ertain times. SS left a message			practice.		
		y member regarding resident		_			
wanting to be transferred to a smoking SNF." A second note, dated, 3-8-18: "MCSS spoke to				Resident no longer resides a	it the		
				facility.			
		him that discharge planning			l		
was taking place as he continues to be non-adherent to care. Resident elected to discharge to home on [local address] and refused				How other residents having	-		
				potential to be affected by t			
				same deficient practice will			
		ent's contact she said will assist			identified and what correct	ive	
	him in getting him	his medications."			actions will be taken?		
	To so today to the	tata Fara di la Dinadana			All residents with the potent		
		th the Executive Director on			return to the community have		
	_	., she indicated the facility had a			potential to be affected by th		
		es Director (SSD) at the time of She shared the SSD "was			alleged deficient practice. An audit of discharge / transfers for the last		
	-	with documentation and things			30 days will be conducted by		
	_	planned discharge [for Resident			DNS / designee to ensure	/ IIIE	
		working with him and Social			accuracy of discharge instru	ctions	
		o get him ready to go home. It			and accurate and complete	Clions	
		al Services did not get much			resident and family education	n	
		npleted on his discharge."			The audit will include Physic		
		inpreted on his disentinge.			ordered discharge medication		
	In an interview wit	th the MDS (Minimum Data Set			and instructions as well as a		
		inator on 7-3-18 at 12:54 p.m.,			needed DME.	,	
	· ·	acility staff were unable to					
		or Resident B's discharge			What measures will be put	into	
	planning.	2			place or what systemic		
	ļ				changes will be made to		
	On 7-3-18 at 12:25	p.m., the MDS Coordinator			ensure that the deficient		
		a policy entitled, "Discharge			practice does not recur?		
		revision date of October, 2017.			A nursing in-service to review	N	
	-	ed, "It is the policy of this [sic]			Discharge Policy and proces		

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to implement an effective, interdisciplinary discharge planning process that focuses on the

resident's discharge goals, the preparation of

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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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EPARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION					
LAND DE LAN OF GODDERGERON	TO ELIMITE O LINE OLIVINI DE ED						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	ľ í	ILDING	onstruction 00	(X3) DATE (COMPL 07/03/	ETED
	PROVIDER OR SUPPLIER		•	2050 CH	ADDRESS, CITY, STATE, ZIP COD HESTER BLVD OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	transition them to preduction of factors readmissions. Disciongoing person-cencaregiver support, gadmission, social seresident's discharge appropriate dischargare appropriate for a collaboration with crepresentative/caregpersons as applicabinembers for a dischappropriate referral obtaining medication will be made as indicated the collaboration and teach wound care, special resident/representation documented in the resident of the collaboration and teach wound care, special resident/representation documented in the resident of the collaboration of the collaboration and teach wound care, special resident/representation of the collaboration and teach wound care, special resident/representation of the collaboration of	tivers or other support le, and appropriate IDT large plan formulation. Is for home health care, le, equipments, treatments licated by the physician. In dientified as needed (i.e., lized diets, etc.) will be given to live or support person and			education will be completed be discharge. All resident Discharges Instructions from the facility will be reviewed by the team to ensure complete and accurate. How will the corrective action be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Ongoing compliance with this corrective action will be monited through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be response for completing the QAPI Audit related to discharges weekly for weeks and monthly for 3 monthly for 3 monthly for 10 monthly for 3 monthly for 10 monthly Assurance and Performance Improvement Completing the 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	ne IDT ns ut ored ible tool or 4 hs. an	
F 0661 SS=D Bldg. 00	-	ary					. I

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMP.			ETED	
		155230	B. W				/2018	
		<u> </u>	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	R			HESTER BLVD			
POSERI	JD VILLAGE				OND, IN 47374			
NOOLDC				KICI IIVI	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	that includes, but	is not limited to, the						
	following:							
	(i) A recapitulation	n of the resident's stay that						
	includes, but is no	ot limited to, diagnoses,						
	course of illness/t	reatment or therapy, and						
	pertinent lab, radi	ology, and consultation						
	results.							
		ry of the resident's status to						
	·	aragraph (b)(1) of §483.20,						
		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							
		edications (both prescribed						
	and over-the-cour	· ·						
		rge plan of care that is						
	-	e participation of the						
	· ·	the resident's consent, the						
		tative(s), which will assist						
	· · · · · · · · · · · · · · · · · · ·	just to his or her new living						
		post-discharge plan of care						
		ere the individual plans to						
		gements that have been						
		dent's follow up care and						
	services.	e medical and non-medical						
		and record review, the facility	F 06	361	(Tag F 661) Discharge		08/02/2018	
		written discharge summary	F 00	001	Summary		08/02/2018	
		rm was completed for 1 of 3			Juninary			
		for discharge planning.			It is the practice of this provide	۵r		
	(Resident B)	Tot angenuige planning.			that residents will discharge from			
	(Resident B)				the facility, as per Physician's	5111		
	Findings include:				order, and that a discharge			
	- mamas morado.				summary is complete.			
	The clinical record	of Resident B was reviewed on			What corrective action(s) wil	ı		
		n. His admission Minimum Data			be accomplished for those	•		
		nent, dated 1-25-18, indicated			residents found to have beer	1		
		rn home. The same MDS			affected by the deficient	-		
	ne expected to retur	in nome. The same MDS			allected by the delicient			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/03/2018 155230 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2050 CHESTER BLVD **ROSEBUD VILLAGE** RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assessment indicated he was cognitively intact. practice. His discharge date was listed as 3-31-18. Resident no longer resides at the Review of the facility's facility. "Discharge/Appointment/Transfer -- ASC Home Discharge Instructions and Information" form for How other residents having the Resident B indicated a significant lack of potential to be affected by the completion of the form. The form was initiated on same deficient practice will be 3-26-18, with completion date of 3-31-18. The form identified and what corrective was missing the following information: actions will be taken? -the resident's community physician or contact All residents with the potential to information or suggested next appointment. return to the community have the -the resident's identified allergies, skin conditions, potential to be affected by the nursing special instructions, any special alleged deficient practice. An audit equipment required. of discharges/transfers for the last -a recap of the resident's stay at the facility, 30 days will be conducted by DNS including admission diagnoses, pertinent or designee to ensure completion findings, summary of treatment course and of discharge summaries. condition upon discharge. -listing of home medications and treatment orders, What measures will be put into including the name of the medication or treatment, place or what systemic dose, frequency, reason for use, time of last changes will be made to administration and for any medications or ensure that the deficient treatments sent with the resident, the amounts of practice does not recur? each and prescription numbers. A nursing in-service to review the -any dietary orders or recommendations. Discharge Policy and process to -any therapy orders or recommendations. include discharge summary will be -identification of the current activity level of the conducted by the DNS or designee on or before 08/02/18. -any vital signs obtained at the time of discharge. Discharge teaching will also be -any signatures of the facility staff or the resident documented in the appropriate to attest the resident received and/or discipline's progress notes. comprehended any discharge instructions Nursing will complete the provided to the resident at the time of discharge, medication portion of the Home nor that the resident received a copy of the Discharge Instructions form and document. ensure that the resident has an adequate supply of medications in On 7-3-18 at 12:25 p.m., the MDS Coordinator accordance with state regulations provided a copy of a policy entitled, "Discharge and/or physicians order.

Planning," with a revision date of October, 2017.

Resident/responsible party will

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155230	B. WING			07/03/	2018
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			HESTER BLVD		
DOCEDI	ום אוו דע כב						
KUSEBU	JD VILLAGE			RICHIVI	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This policy indicate	ed, "It is the policy of this [sic]			sign the discharge form		
	to implement an eff	ective, interdisciplinary			acknowledging understanding	of	
	discharge planning	process that focuses on the			the discharge instructions,		
	resident's discharge	goals, the preparation of			including medication		
	residents to be activ	ve partners and effectively			administration. Medication		
	transition them to p	ost-discharge care, and the			administration should be writte	en in	
	reduction of factors	leading to preventable			lay terms. Social Service will		
	readmissions. Disc	harge planning will include an			initiate contact with a home he	alth	
		tered evaluation of needs,			agency to ensure continuity of		
	caregiver support, g	goals and preferencesUpon			care and will coordinate equip	ment	
	admission, social services will assist in identifying				delivery to the resident's home	e as	
	resident's discharge planning goal and initiate				deemed appropriate by the		
	appropriate discharge planningResidents that				discharge plans. Social Servic	e	
	are appropriate for discharge planning will have				will assist arranging special		
	collaboration with o	desired			transportation if required.		
	representative/careg	givers or other support			Administrator/DNS/Designee v	will	
	persons as applicab	le, and appropriate IDT			review all open discharges dai	ily	
	members for a discl	harge plan formulation.			during morning clinical meeting	g to	
	Appropriate referra	ls for home health care,			ensure all areas of discharge		
	obtaining medication	ons, equipments, treatments			summary form have been		
	will be made as ind	icated by the physician.			completed before discharge of		
	Education and teach	ning identified as needed (i.e.,			resident.		
	wound care, special	lized diets, etc.) will be given to					
	•	rive or support person and			How will the corrective action	ns	
		medical recordFor discharges			be maintained to ensure the		
		order to home: Home discharge			deficient practice will not		
	instructions will be	completed by the IDT			recur, i.e., what quality		
	_	on list and follow up			assurance program will be p	ut	
	appointments as sch	neduled. The Home Discharge			into place?		
	Instructions will be	reviewed and signed by the			To ensure compliance with this	S	
	•	tive in a manner they are able			corrective action, the		
		by of the Home Discharge			DNS/designee will complete the	ne	
	Instructions will be	_			CQI tool titled, "Discharge		
	resident/representat	ive."			Planning". This tool will be		
					completed weekly for 4 weeks		
	This Federal tag rel	ates to Complaint IN00256240.			followed by monthly for 6 mon		
					If threshold of 90% is not met,	an	
	3.1-36(a)(1)				action plan will be developed.		
	3.1-36(a)(2)				Findings will be		
	3.1-36(a)(3)				submitted to the CQI Committe	ee	

CLIVILIOIO	K MEDICINE & MEDIC	THE SERVICES			ONID 110: 0700 007	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155230	B. WING		07/03/2018	
	PROVIDER OR SUPPLIED	R	2050 0	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD MOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	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	483.40(d)					
SS=D	` '	cally Related Social Service				
Bldg. 00		acility must provide				
Ū	, ,	social services to attain or				
	1	est practicable physical,				
		osocial well-being of each				
	resident.					
		and record review, the facility	F 0745	(Tag F 745)	08/02/2018	
		services of the Social Services	1 0/43	What corrective action(s) will		
		ropriate to meet the discharge		be accomplished for those		
		1 of 3 residents reviewed for		residents found to have been		
	discharge planning			affected by the deficient		
	discharge planning	. (Resident B)		practice:		
	Findings include:			The resident found to have been	an l	
	i manigs merade.			affected by the deficient practic		
	The clinical record	of Resident B was reviewed on		was discharged to the commun		
		His admission Minimum Data		and is no longer residing at the	-	
		nent, dated 1-25-18, indicated				
		rn home, but no discharge		facility.		
	1 -	had been initiated at that time.		How other residents having the	ho	
		sessment indicated he was		How other residents having the potential to be affected by the		
		His discharge date was listed		same deficient practice will be		
	as 3-31-18.	This discharge date was listed		<u>-</u>		
	us 3-31-10.			identified and what corrective action(s) will be taken;	,	
	Review of the clini	cal record indicated a lack of		All residents with the potential	to	
		ted to care plan development		return to the community have the		
		ge planning for Resident B, for		potential to be affected by the	IIC	
		nent and documentation in		alleged deficient practice.		
		s of progression toward		All resident with preferences to		
	discharge.	s of progression toward		•		
	uischarge.			return to the community care		
	To an index :	h the MDS (Minimum Data Set		plans will be audited for		
	T III an interview wit	n meavida uvimimim Daia Ser	1	I COUNDIEUON AND TO ENGLIFE		

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assessment) Coordinator on 7-3-18 at 12:54 p.m.,

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discharge activities are occurring.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/03/2018	
	PROVIDER OR SUPPLIE	R	2050 C	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD MOND, IN 47374	
ROSEB (X4) ID PREFIX TAG	summary (EACH DEFICIE REGULATORY O she indicated the fi locate a care plan i planning. In an interview wi 7-2-18 at 4:09 p.m new Social Service Resident B's stay. having a hard time like thatIt was a B]. Therapy was v Services in order t looks like the Soci documentation cor In an interview wi 7-3-18 at 11:25 a.r some issues with t B's stay and discha long-term care." I Executive Director	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL RELSC IDENTIFYING INFORMATION acility staff were unable to for Resident B's discharge the the Executive Director on, she indicated the facility had a ses Director (SSD) at the time of She shared the SSD "was with documentation and things planned discharge [for Resident working with him and Social to get him ready to go home. It al Services did not get much mpleted on his discharge." the the Executive Director on m., she indicated the facility had the SSD at the time of Resident targe. "She was new to on an interview with the or on 7-3-18 at 2:15 p.m., she was hired on 10-4-2017, and is			Mill ee S 18 ees 10 olicy
	no longer employe 5-15-2018.	elates to Complaint IN00256240.		SS Consultant will be notified discharges to home weekly fo review x 4 weeks. SSD will attend, at minimum of 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 to will be utilized weekly x 4 weemonthly x 6 months, and quarthereafter for one year with reserved.	r one ge che e e; ool ks, terly

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
15		155230	B. WING			07/03/2018	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE VIVOR CONTROL	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0842 SS=D Bldg. 00	§483.20(f)(5) Resi (i) A facility may no is resident-identifia (ii) The facility may resident-identifiable accordance with a agent agrees not to information except itself is permitted to §483.70(i) Medical §483.70(i)(1) In according to the confidential (i) Complete; (ii) Accurately doccording Readily access (iv) Systematically §483.70(i)(2) The confidential all information resident's records,	- Identifiable Information dent-identifiable information. of release information that able to the public. It release information that is deto an agent only in contract under which the of use or disclose the deto the extent the facility of do so. I records. I records. I records with accepted deards and practices, the deain medical records on are- umented; sible; and de organized facility must keep formation contained in the corm or storage method of out when release is-			reported to the Quality Assura 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 compliant. By what date the systemic changes will be completed; August 2, 2018	e e	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/03/2018				
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			2050 0	STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE COMPLETION				
TAG		ere permitted by applicable	TAG	DEFICIENCY)	DATE				
	(ii) Required by La (iii) For treatment, operations, as per compliance with 4 (iv) For public hea abuse, neglect, or oversight activities proceedings, law organ donation pu or to coroners, me directors, and to a	payment, or health care mitted by and in 5 CFR 164.506; lth activities, reporting of domestic violence, health s, judicial and administrative enforcement purposes, proses, research purposes, edical examiners, funeral evert a serious threat to s permitted by and in							
		facility must safeguard ormation against loss, authorized use.							
	retained for- (i) The period of ti (ii) Five years fron when there is no r	ical records must be me required by State law; or the date of discharge equirement in State law; or years after a resident under State law.							
	contain- (i) Sufficient information resident; (ii) A record of the (iii) The comprehe services provided (iv) The results of screening and resideterminations co	any preadmission ident review evaluations and nducted by the State; irse's, and other licensed							

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STATEMENT OF DEFICIENCIES X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155230		B. WI	NG		07/03/2018		
			_	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			HESTER BLVD		
ROSEBUD VILLAGE				RICHM	OND, IN 47374		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		adiology and other diagnostic					
		as required under §483.50.	F 00	. 40		00/02/2010	
		and record review, the facility	F 08	342	(Tag F 842) Resident	08/02/2018	
		inventory record of the			Records-Identifiable		
	_	belongings was completed			Information	4-	
		upon the resident's discharge			It is the practice of this facility		
	1	r 1 of 3 residents reviewed for			complete and maintain invent	-	
	discharge.				records of resident's personal	•	
	Findings include:				belongings upon admission and discharge from the facility.	,iu	
	Tillungs include.				What corrective action(s) wi		
	The clinical record of Resident B was reviewed on				be accomplished for those	11	
	7-2-18 at 11:24 a.m. His admission date was listed				residents found to have bee	n	
	as 1-18-18. His discharge date was listed as				affected by the deficient		
	3-31-18.	senarge date was risted as			practice.		
					practice.		
	An "Inventory of Personal Belongings" form for				Resident no longer resides at	the	
	Resident B indicated the listed items were				facility.		
	inventoried on 3-2-18 by a staff member. The						
	document was not dated or signed by facility staff				How other residents having	the	
	or the resident for the "Admission" portion or the				potential to be affected by the		
	discharge portion of the document. A				same deficient practice will	be	
	handwritten notation was located on the facility's			identified and what co		re e	
	"Discharge/Appointment/Transfer ASC Home				actions will be taken?		
	Discharge Instructions and Information" form for			All residents with the pe		l to	
	Resident B, dated 3-31-18 at 5:45 p.m., stating,				return to the community have	the	
	"Res[ident] taking all personal belongings with			potential to be affe			
	him." It was signed by Resident B, but was				alleged deficient practice. An	audit	
	unsigned by facility staff. The notation did not				of admissions /		
	specify what items were taken by Resident B.				discharges/transfers for the la		
	0.5010.11025				days will be conducted by DN		
	On 7-3-18 at 12:25 p.m., the MDS Coordinator				designee to ensure completio	n of	
	provided a copy of a policy entitled, "Discharge				inventory records.		
	Planning," with a revision date of October, 2017.						
	This policy indicated, "The inventory of the) NA//	-4-	
	resident's personal belongings should be			What measures will be		ιτο	
	reviewed and signed by staff and			place or what systemic			
	resident/responsibl	e party.			changes will be made to		
	This Federal tag relates to Complaint IN00256240.				ensure that the deficient		
					practice does not recur?		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC					ON	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
This Termy of Countries		155230	B. WING			07/03	
		100200	D. 111			01700	72010
NAME OF B	DOLUBED OF GUIDN IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	C		2050 C	HESTER BLVD		
ROSEBU	D VILLAGE				OND, IN 47374		
ROOLBO	D VILLAGE			TAIOTIM			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\IE	DATE
					A nursing in-service to review		
	3.1-50(a)(1)						
					admit / discharge to include		
	3.1-50(a)(2)				resident inventory process wil		
					conducted by the DNS / desig		
					by 08/02/18. IDT will review	new	
					admissions / discharges to en	sure	
					inventory records are complet	e.	
					How will the corrective actio	ns	
					be maintained to ensure the		
					deficient practice will not		
					-		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					To ensure compliance with thi	is	
					corrective action, the		
					DNS/designee will complete tl	he	
					CQI tool titled, "Discharge		
					Planning." This tool will be		
					_		
					completed weekly for 4 weeks		
					followed by monthly for 6 mon		
					If threshold of 90% is not met,	an	
					action plan will be developed.		
					Findings will be submitted to t	he	
					CQI Committee for review and	t	
					follow up.		
					By what Date the systemic		
					1 -		
					changes for each deficiency		
					will be completed.		
					August 2, 2018		
			1		I		1

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