STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	10/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00211312. This visit was in conjunction with the Investigation of Complaint IN00213476. Complaint IN00211312 - Substantiated. Federal/State deficiencies related to the allegations are cited at F242. Complaint IN00213476 - Substantiated. Federal/State deficiencies related to the allegations are cited at F315. Survey dates: October 24, 25, 26, 27, and 28, 2016. Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF: 26 SNF/NF: 96 Total: 122 Census payor type: Medicare: 26 Medicaid: 76	F 0000		

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

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	Other: 20 Total: 122 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 11/2/16.			
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to the use of self release belts for 1 of 3 residents reviewed for physical restraints. (Resident #47) Finding includes: During a continuous observation on 10/26/16 from 8:52 a.m. until 10:55 a.m., Resident #47 was observed sitting in a wheelchair in front of a television across the hall from the dining area. He wore a seat belt restraint around his waist. The resident was not observed attempting to	F 0221	**F221** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the*	11/27/2016

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	self transfer nor was he observed sliding from the wheelchair. On 10/27/16 at 10:21 a.m., the resident was observed sitting in a wheelchair in front of a television across the hall from the dining area. He was observed with a seat belt restraint around his waist. The resident was not observed attempting to self transfer nor was he observed sliding from the wheelchair. At 11:27 a.m., the resident was wheeled to the dining room and seated at the table, the belt remained in place. At 12:00 p.m., the resident was observed feeding himself, no attempts were made to self transfer nor was he sliding from the wheelchair, and the belt remained in place. The record for Resident #47 was reviewed on 10/26/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia with behaviors, anxiety, and muscle weakness. The Annual Minimum Data Set (MDS) assessment dated 5/8/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating he was severely cognitively impaired for decision making. The resident needed extensive assist with a 2 person physical assist for transfers. The resident had no falls since the last assessment. The		*truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The order for a seat belt was discontinued for resident #47. **2) How the facility identified other residents:** The other two residents with seatbelts or other restraints were reviewed for appropriate diagnosis. Both residents had appropriate diagnosis for restraint use. **3) Measures put into place/ System changes:** Staff will be in-serviced on the	

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	resident was coded as having a restraint. The current and updated plan of care dated 5/24/16 indicated the resident had a sounding self release belt related to his diagnosis of dementia and could not release the belt on his own consistently. The interventions included, but were not limited to, release the belt every two hours and during dining. A Physician's Order dated 1/4/16, indicated may use sounding self release belt, check every hour, release every two hours and as needed for care and positioning. The Restraint Evaluation and Review dated 6/22/16, indicated physical restraint evaluation observation related to unsteady gait, frequent falls, sliding out of wheelchair, attempts to self transfer, impulsive in movements, poor safety awareness and falls, daughter requested to use belt to aide in reminding the resident to wait for assist with transfers. Interview with the Director of Nursing (DON) on 10/27/16 at 2:07 p.m., indicated the resident's sounding self release belt should be released every two hours and during dining according to his plan of care. The resident had not been exhibiting poor safety awareness related		right to be free from physical restraints and our restraint policy. Any new restraint orders will be reviewed in Clinical meeting on the next business day for appropriateness. All restraints will be reviewed in each QA meeting and a trial reduction attempted at least quarterly. **4) How the corrective actions will be monitored:** An audit tool was devised to review restraints for appropriate diagnosis/ reason for use. Audit tool will be completed with each new restraint order and monthly on existing restraints under the supervision of the DON or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	

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	to attempting to self transfer, impulsive movements, or sliding from his wheelchair and should probably be reassessed for a less restrictive intervention. The current Resident Restraints policy, provided by the DON on 10/27/16 at 3:21 p.m., indicated, "...Definitions:..also included as restraints are facility practices that meet the definition of a restraint, such as,...Self-Release Belts, if the resident is physically or mentally incapable of releasing the belt...Procedure:..2. The use of restraints will be reviewed by the Interdisciplinary Team periodically and at least Quarterly thereafter...14. The decision to use restraints is never based solely on the resident's representative's request for use...." 3.1-3(w)			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained	F 0241	**F241**	11/27/2016

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	related to ensuring a resident voicing the need to use the restroom was toileted timely, speaking to a resident insensitively, and ensuring a resident's urinary drainage bag was covered for 1 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Residents #24, #98, and #E) Findings include: 1. On 10/24/16 at 10:55 a.m., Resident #24 was observed seated at a table in front of the Nursing station. At the time, she voiced the need to be toileted. Activity Aide #1 responded by telling the resident she would find someone to assist her to the bathroom. The resident replied by saying, "I'm gonna go before you get back." The aide walked away and returned shortly. As the resident continued to wait for assistance, a resident who was also seated at the table blurted, "She better not boo boo on herself!" Then another resident at the table replied, "Yeah, I don't want to smell you!" At 11:01 a.m., Restorative Aide #1 walked passed the table and asked the Activity Aide if the resident had been toileted yet, the resident remained at the table. At 11:03 a.m., LPN #5 walked to the table and handed the resident a half		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #24 was toileted. Restorative Aide #1 and LPN #5 were in-serviced on the need for prompt toileting. Conversation during dining for resident #98 are culturally appropriate. Restorative Aide #1 was in-serviced on appropriate topics of conversation and cultural sensitivity. The catheter bag for Resident #E was removed from the floor and covered.	

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	peeled banana, the resident remained at the table. At 11:09 a.m., the resident was wheeled to the restroom by Restorative Aide #1. The resident was now refusing to be toileted indicating, "I went already." At 11:24 a.m., CNA #4 was observed carrying a brief and a change of pants from the resident's room toward the restroom. Interview at the time, indicated the resident had a bowel movement and required changing. 2. On 10/24/16 at 8:37 a.m., the breakfast dining observation was observed. Restorative Aide #1 was observed seated at the dining table assisting a resident with eating and was speaking across the table discussing dinner plans for Thanksgiving. Resident #98 was seated at the table to the right of the Aide and feeding herself a bowl of cereal. At this time, the Aide asked Resident #98, "Do you guys eat turkey for Thanksgiving or do you guys eat ham hocks?" Another CNA who was seated across the table from Resident #98 shook her head. Resident #98's record was reviewed on 10/27/16 at 10:25 a.m. Diagnoses included, but were not limited to, dementia with behaviors and anxiety.		**2) How the facility identified other residents:** Any resident who requires assistance with toileting could potentially be affected. Any resident with a Foley catheter could potentially be affected. Any resident who is of a different cultural background than the caregiver could potentially be affected. **3) Measures put into place/ System changes:** Staff in all departments will be educated on appropriate topics of conversation and cultural sensitivity. Staff will be in-serviced on the necessity for prompt toileting. Staff will be educated on the proper placement of catheter bags and the use of covers. Facility purchased additional catheter bag covers. **4) How the corrective actions will be monitored:** An audit tool was devised to	

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	The Quarterly Minimum Data Set (MDS) assessment dated 9/22/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 99, meaning she was unable to complete the interview. Interview with the Director of Nursing (DON) on 10/27/16 at 2:07 p.m., indicated the Aide was culturally insensitive when speaking with the resident. 3. On 10/24/16 at 6:24 a.m., Resident #E was observed in her room in bed. At that time, the foley catheter (urinary) drainage bag was resting on the floor uncovered, visible from inside the doorway. On 10/25/16 at 9:25 a.m., the resident's foley catheter drainage bag was observed resting on the floor uncovered. Interview with LPN #3 at the time, indicated the foley catheter drainage bag should not have been uncovered nor should it have been laying on the floor. The record for Resident #E was reviewed on 10/26/16 at 10:40 a.m. The resident's diagnoses included, but were not limited to, neurogenic bladder, non-Alzheimer dementia, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 9/14/2016, indicated the resident had a Brief Interview for		monitor for correct placement and covering of catheter. Audit will be completed under the direction of the DON or designee 3x weekly on a variety of shifts for each resident with a Foley Catheter. An audit tool was devised to monitor interactions with residents for appropriateness. Audit will be completed 3x weekly during a variety of settings on different shifts for the appropriateness of conversation under the supervision of Social Services or designee. An audit tool was devised to monitor for prompt toileting of residents. Audit will be completed 5x weekly by the DON or designee on a variety of shifts. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	

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	Mental Status (BIMS) score of 12, meaning her cognition was moderately impaired. Interview with the Director of Nursing on 10/28/16 at 11:01 a.m., indicated the resident's foley catheter drainage bag should have been in a dignity bag and not on the floor. 3.1-3(t)			
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure a resident's choice was honored related to their preference for waking up in the morning for 2 of 3 residents reviewed for choices of the 7 who met the criteria for choices. (Residents #B and #C) Findings include: 1. On 10/24/16 at 6:00 a.m., Resident #B was observed in his room in bed. At 8:30	F 0242	**F242** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	11/27/2016

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	a.m., in the 300 unit dining room, Dietary Employee #1 was asking if the resident was in the dining room. The resident arrived in the dining room at 8:30 a.m. Interview with CNA #6 on 10/24/16 at 8:40 a.m., indicated the midnight shift does not have any early get ups due to having only one CNA. She indicated they start getting residents up on the day shift which starts at 6:00 a.m. Interview with the resident on 10/25/16 at 8:58 a.m., indicated that he prefers to get up early. He indicated that lately, he has been the last person to breakfast. On 10/26/16 at 7:45 a.m., the resident was observed in bed. The resident was awake at this time and his call light was on. QMA #2 answered the call light around 7:50 a.m. and asked the resident what he wanted. The resident indicated he was ready to get up. The QMA told the resident, "the girls are busy, one is with one resident and the other one is with someone else and he would have to wait." The resident indicated he was not happy with this. The resident was observed going to the dining room for breakfast at 8:30 a.m. The record for Resident #B was reviewed on 10/26/16 at 8:34 a.m. The resident's		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #B was assisted to wake up at his preferred time. Resident #C medication order was changed to coincide with her preferred time for rising. **2) How the facility identified other residents:** All interviewable residents were asked for an updated preference for rising time. **3) Measures put into place/ System changes:** Preferred rising time added to	

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	diagnoses included, but were not limited to, muscle weakness, hemiplegia (weakness) and cerebrovascular disease (stroke). The 8/4/16 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was extensive assist for transfers. The resident also required two or more people to assist with the transfer. The resident's Brief Interview for Mental Status (BIMS) score was 15 and he was cognitively intact. The current plan of care dated 8/2016, indicated the resident had an Activities of Daily Living (ADL) self care deficit. The Nursing approaches were to honor the resident's preferences. The 10/18/16 Activity Preference Interview, indicated the resident's preferred waking time was 6:00 a.m. Interview with the Director of Nursing on 10/28/16 at 11:30 a.m., indicated the resident should have been getting up at his preferred time. 2. Interview with Resident #C on 10/25/16 at 11:32 a.m., indicated she had no choice of when she wanted to get up in the morning. The resident indicated she received a medication at 6:00 a.m., however, sometimes the Nurse will come		CNA assignments. Staff educated on the importance of honoring all preferences. **4) How the corrective actions will be monitored:** An audit tool was created to monitor if residents are assisted in rising at their preferred time and that other preferences are honored as well. Audit will be completed under the supervision of DON or designee 5 times weekly on a sample of five residents to determine if their preferences were honored. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	

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	in at 5:00 a.m., and give me the medication and "I do not like to get up that early." She indicated she preferred to get up closer to 7:00 a.m. The record for Resident #C was reviewed on 10/26/16 at 8:08 a.m. The resident was newly admitted to the facility on 10/7/16. The resident's diagnoses included, but were not limited to, muscle weakness, history of falling, type 2 diabetes, high blood pressure, spinal stenosis, and anxiety. The Admission Minimum Data Set (MDS) assessment dated 10/15/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 and was cognitively intact. It was very important to the resident to choose her own bedtime. The current plan of care dated 10/2016, indicated the resident had an Activities of Daily Living (ADL) self care deficit. The Nursing approaches were to honor the resident's preferences. The resident preference/MDS interview dated 10/11/16, indicated the resident's preferred rising time was at 7:00 a.m. The Medication Administration Record (MAR) for the month of 10/2016,			

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	indicated the resident received the medication of Gabapentin (a medication to treat nerve pain) 800 milligrams (mg) 1 tablet three times a day for pain. The scheduled times were 6:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was signed out as being administered at the following times: 10/8/16 at 5:52 a.m. 10/9/16 at 6:12 a.m. 10/10/16 at 5:57 a.m. 10/11/16 at 5:06 a.m. 10/12/16 at 5:02 a.m. 10/13/16 at 5:25 a.m. 10/14/16 at 5:59 a.m. 10/15/16 at 6:13 a.m. 10/16/16 at 5:16 a.m. 10/17/16 at 5:26 a.m. 10/18/16 at 5:02 a.m. 10/19/16 at 5:21 a.m. 10/20/16 at 5:02 a.m. 10/21/16 at 5:11 a.m. 10/22/16 at 5:14 a.m. 10/23/16 at 6:04 a.m. 10/24/16 at 6:08 a.m. 10/25/16 at 5:06 a.m. 10/26/16 at 5:48 a.m. Interview with the Assistant Director of Nursing (ADON) #1 on 10/26/16 at 9:55 a.m., indicated the resident's preference was to be up at 7:00 a.m. according to her preference sheet.			

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	This Federal tag relates to Complaint IN00211312. 3.1-3(u)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure the plan of care was followed related to releasing restraints during meals for 1 of 24 care plans reviewed. (Resident #14) Finding includes: On 10/24/16 at 8:11 a.m., Resident #14 was observed with a lap buddy restraint to her wheelchair. The resident was in the 300 unit dining room at this time. She was being assisted with her meal by RN #1. The RN did not remove the resident's lap buddy. On 10/28/16 at 12:34 p.m., the resident was observed in the 300 unit dining room being assisted with lunch. The resident's lap buddy was not released at this time.	F 0282	**F282** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	11/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	10/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	The record for Resident #14 was reviewed on 10/26/16 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavior disturbance and history of falling. A Physician's order dated 10/23/16, indicated the resident was to have a lap buddy while up in the wheelchair. The lap buddy was to be checked every half hour and removed every two hours. The plan of care dated 10/25/16, indicated the resident required the use of a restraint enabler, use of physical restraint related to medical symptom for which restraint/enabler is used to treat: anxiety, restlessness, decreased safety awareness. Resident/family is aware of the risks associated with use of above device. The interventions included, but were not limited to, release with meals, ADL's (activities of daily living), toileting, and care provisions. Interview with Assistant Director of Nursing #2 on 10/28/16 at 2:18 p.m., indicated the care plan noted the resident's restraint should be released at meals. 3.1-35(g)(2)		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #14 had her lap buddy released during meals. **2) How the facility identified other residents:** There were two other residents with restraints who could potentially be affected. **3) Measures put into place/ System changes:** Staff was educated on the importance of following the plan of care. **4) How the corrective actions will be monitored:** An audit was devised to ensure	

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			plan of care was followed. Audit will be completed 3 times/week on a variety of shifts by DON or designee on all residents with restraints to determine if plan of care for releasing is being followed, and 3 times/ week on five residents to determine if all areas of plan of care are being followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27,2016	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to monitor	F 0309	**F309**	11/27/2016

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	and document bruises for 1 of 3 residents reviewed for non-pressure related skin conditions of the 6 residents who met the criteria for non-pressure related skin conditions. (Resident #24) Finding includes: On 10/24/16 at 11:04 a.m., Resident #24 was observed with multiple reddened and scabbed areas to the top of her bilateral forearms. She was also observed with a purplish and fading bruise to the top of her right hand. The record for Resident #24 was reviewed on 10/26/16 at 1:47 p.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, depression, and hypertension. The Quarterly Minimum Data Set (MDS) assessment dated 9/1/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 and was severely cognitively impaired for decision making. The resident was an extensive assist with 1 person physical assist for transfers. The plan of care indicated the resident had a potential for impaired skin integrity. The interventions included, but were not limited to, discourage resident		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident # 24 placed on monitoring for identified skin areas. **2) How the facility identified other residents:**	

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	from scratching and picking at skin. The Admission/Readmission Observation dated 10/21/16 indicated, left posterior forearm 8 centimeters (cm) x 4.2 cm purplish yellow bruise, left posterior forearm scabbed area 1.4 cm in length surrounded by redness 3.1 x 2.2 cm, right hand 3.6 cm x 4 cm greenish purple bruise, right antecubital 4.8 cm x 3.4 cm purple bruise, anterior forearm purple bruise 2.5 cm x 3.3 cm, right posterior forearm 7 round pink scared areas approximately 1 cm in diameter. The Nursing Progress notes dated 10/21/16 to 10/26/16 indicated no non-pressure skin related concerns. The 10/2016 Treatment Administration Record indicated no monitoring of non-pressure skin related concerns. Interview with LPN #6 on 10/26/16 at 11:34 a.m., indicated the resident was probably admitted with the non-pressure skin areas and they were not currently being monitored. Interview with LPN #7 on 10/26/16, indicated the resident was readmitted to the facility on 10/21/16, the non-pressure skin areas were assessed, and they should have been monitored.		All residents with identified skin issues were reviewed to determine if orders were placed on the TAR for monitoring. **3) Measures put into place/ System changes:** Nurses educated to put orders for monitoring all identified skin issues in the TAR at the time they are identified. **4) How the corrective actions will be monitored:** An audit tool was devised to determine if appropriate monitoring for skin conditions is occurring. All new admissions and readmissions will be audited by DON or designee five times a week to determine if monitoring is on the TAR as appropriate. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	Interview with the Director of Nursing (DON) on 10/27/16 at 2:07 p.m., indicated the nursing staff should have been monitoring and documenting the residents non-pressure skin areas. The current Pressure Ulcer and Skin Condition Assessment policy dated 1/1/15 provided by the DON on 10/27/16 at 3:21 p.m., indicated "At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative, and attending Physician will be notified. The DON will be notified on a daily basis by the use of the 24 Hour Report and a skin assessment will be initiated. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes." 3.1-37(a)		**5) Date of compliance:** November 27, 2016	
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure urinary catheter drainage bags were not positioned on the floor for 2 of 2 residents reviewed for urinary catheter use. (Residents #D and #E) Findings include: 1. On 10/27/16 at 1:45 p.m., Resident #D was observed in her room in bed. The resident's foley catheter (urinary) drainage bag was directly on the floor underneath the resident's bed and not inside a dignity bag. The record for Resident #D was reviewed on 10/27/16 at 10:21 a.m. The resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and chronic kidney disease. A Physician's order dated 6/10/16, indicated the resident's foley catheter and bag were to be changed as needed and foley catheter care was to be completed every shift. The current plan of care indicated the resident had an indwelling catheter related to neurogenic bladder. The	F 0315	**F315** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The catheter bag for Resident #D and #E was removed from the floor and covered.	11/27/2016

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	interventions included, but were not limited to, resident has 16 french, 10 cc (cubic centimeter) foley catheter, position catheter bag and tubing below the level of the bladder and away from entrance room door. Interview with the Director of Nursing on 10/28/16 at 11:30 a.m., indicated the resident's foley catheter drainage bag should not have been on the floor underneath the resident's bed. 2. On 10/24/16 at 6:24 a.m., Resident #E was observed in her room in bed. At that time, the foley catheter drainage bag was laying on the floor uncovered. On 10/25/16 at 9:25 a.m., the resident's foley catheter drainage bag was observed on the floor uncovered. Interview with LPN #3 at that time, indicated the foley catheter drainage bag should not have been uncovered nor should it have been laying on the floor. The record for Resident #E was reviewed on 10/26/16 at 10:40 a.m. The resident's diagnoses included, but were not limited to, neurogenic bladder, non-alzheimers dementia, and chronic kidney disease. The Care Plan dated 9/9/16, indicated the resident had an indwelling catheter. The nursing interventions were to change		**2) How the facility identified other residents:** Any resident with a Foley catheter could potentially be affected. **3) Measures put into place/ System changes:** Staff will be educated on the proper placement of catheter bags and the use of covers. Facility purchased additional catheter bag covers. **4) How the corrective actions will be monitored:** An audit was devised to monitor for proper placement and covering of catheter bags. Audit will be completed under the direction of the DON or designee 3x weekly on a variety of shifts for compliance with catheter bag placement and cover for each resident with a Foley Catheter. The results of these audits will be	

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	monthly, perform urinary catheter care, and report any signs or symptoms of urinary tract infection (UTI). Interview with the Director of Nursing (DON) on 10/28/16 at 11:01 a.m., indicated it was facility policy to keep the foley catheter drainage bag from touching the floor. Review of the facility Urinary Catheter Care Policy, received as current from the DON on 10/28/16 at 11:30 a.m., indicated urinary catheter drainage bags and tubing were to be positioned to prevent touching the floor. This Federal Tag relates to Complaint IN00213476. 3.1-41(a)(2)		reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	
F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or			

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	gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastronomy (PEG) tubes received the necessary care and treatments related to medication administration for 1 of 1 resident reviewed for PEG tubes. (Resident #86) Finding includes: On 10/27/16 at 12:14 p.m., LPN #3 was observed preparing medications for Resident #86. She dispensed one pill from her medication cart then poured the contents into a plastic pill cup. The LPN then walked into the resident's room and donned clean gloves. She placed her stethoscope over the resident's stomach and listened for bowel sounds, at this time she did not check for tube placement. The LPN then proceeded to check for residual via syringe and administer the resident's medication. Interview at the time with LPN #3, indicated she should have checked the resident's tube for proper placement prior to administering the medication.	F 0322	**F322** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** G-Tube placement was checked	11/27/2016

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	The record for Resident #86 was reviewed on 10/27/16 at 12:49 p.m. The resident's diagnoses included, but were not limited to, dementia, aspergers, and PEG-tube. The current care plan indicated the resident had a PEG-tube related to nothing by mouth. The interventions included, but were not limited to, check tube for placement by aspiration/auscultation every shift and with medication administration. Interview with the Director of Nursing (DON) on 10/27/16 at 2:07 p.m., indicated nursing staff should check for placement before each medication administration. The current Medication Administration: TUBE-GASTROSTOMY policy provided by the DON on 10/27/16 at 3:21 p.m., indicated "VERIFYING THE TUBE PLACEMENT VIA ASPIRATION: Test before each feeding, administration of medication, ..." 3.1-44(a)(2)		for Resident #86. LPN #3 educated on checking placement prior to administering medication. **2) How the facility identified other residents:** Any resident with a G-Tube could potentially be affected. **3) Measures put into place/ System changes:** Nurses educated on checking placement of G-Tubes prior to administering medications. **4) How the corrective actions will be monitored:** An audit was devised to monitor checking G-Tube placement prior to medication administration. An audit will be completed 3x weekly on varying shifts under the supervision of the DON or designee to monitor for compliance with checking G-Tube placement prior to medication administration.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure smoking materials were secured in resident rooms for 1 of 2 residents who smoked on the 400 unit. The facility also failed to ensure siderails were secured to the bed for 1 of 40 residents observed for siderails, and heated plate warmers used to serve food were supervised for 1 of 4 units. (Residents #20, #49, and the 100 unit) Findings include:	F 0323	**F323** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	11/27/2016

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	1. During a room observation on 10/26/16 at 9:35 a.m. and 2:01 p.m., Resident #20 was out to dialysis. At those times, there was a pack of cigarettes laying on the table in her room. The cigarettes were not secured and were in plain view. During a room observation on 10/27/16 at 9:01 a.m. and 2:01 p.m., the resident was not in her room. At those times, there was a pack of cigarettes laying on the table in her room. The cigarettes were not secured and were in plain view. The record for Resident #20 was reviewed on 10/27/16 at 2:43 p.m. The resident was newly admitted to the facility on 9/16/16. The resident's diagnoses included, but were not limited to, asthma, muscle weakness, difficulty walking, end stage renal disease, renal dialysis, heart failure, high blood pressure, sleep apnea, anemia, nicotine dependence, and diabetes type 2. The Admission Minimum Data Set (MDS) assessment dated 9/24/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 and she was cognitively intact. A smoking assessment dated 9/22/16 and 10/25/16, indicated the resident		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #20 has discharged. The residents on the 100 unit received supervision when the carts were on the unit. The side rails for Resident #49 were tightened. **2) How the facility identified other residents:** Residents in possession of smoking materials could potentially be affected. Residents on the 100 unit could potentially be affected by unsupervised food carts. Any resident using side rails could be affected. **3) Measures put into place/ System changes:**	

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	may independently be able to handle smoking materials. Interview with the Administrator on 10/28/16 at 9:30 a.m., indicated smoking materials were to be locked or secured in the resident's room, when the resident was not in the room. 2. On 10/24/16 at 7:38 a.m., two food carts were delivered to the independent and assisted dining rooms on the 100 unit. There were 2 heated warmers stored on the top shelf of each cart. The warmers were observed plugged into the wall by the entrances of each dining room. Both carts were left unattended. The cart's temperature gauges were set at 7. The sides of the warmers on each cart were hot to touch. There were no residents observed near the carts. There were 28 residents who resided on the unit. Interview with LPN #5 on 10/24/16 at 11:47 a.m., indicated she was unsure of the facility's policy related to ensuring residents were free from potential harm related to the food warmers being left unattended during dining. Interview with the Administrator on 10/24/16 at 11:50 a.m., indicated the food warmers should not have been delivered to the unit and left unattended. The		Educate staff on the policy for smoking materials. Offered a locked drawer to residents who are in possession of smoking materials and do not want to carry them at all times. Procedure for delivering food carts to the 100 unit changed to require a call from nursing department prior to being delivered from dietary. Staff educated on the new procedure for 100 unit food carts. All side rails checked and work orders placed for any that were loose. All repairs will be completed. All side rails to be checked monthly and tightened as needed by maintenance. Staff educated on checking rails with daily use and completing work orders as needed. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor for proper storage of smoking materials. Audit will be completed on varying shifts under the supervision of DON or designee 5 times per week for smoking materials not properly stored. An audit tool was devised to monitor for proper deliver and supervision of the food carts on	

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	155156	A. BUILDING 00 B. WING	10/28/2016

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	dietary staff were to announce the carts had arrived to the unit and staff were to go into the dining rooms, however, if staff were completing other tasks the carts would be left unattended. She further indicated the staff would call the dining room when they were ready for the carts to be delivered. 3. On 10/25/16 at 10:01 a.m., the left and right side rails for Resident #49 were observed in the upright position on the bed. At that time, the rails were loose and wobbled back and forth. On 10/26/16 at 2:56 p.m. and 10/27/16 at 9:00 a.m., the left and right side rails were observed in the down position on the bed. At those times, the rails were loose and wobbled back and forth. Interview with the Maintenance Director on 10/27/16 at 2:48 p.m., indicated he was unaware the rails were loose. He further indicated the rails were not supposed to be loose and needed to be fixed. 3.1-45(a)(2)		the 100 unit. Audit will be completed under the supervision of DON or designee 3x weekly during varying meals for proper delivery and supervision of the food cart. An audit tool was devised to monitor side rails. Audit will be completed under the supervision of Maintenance or designee 3x weekly on 3 rooms on varying units for side rails needing adjusted. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	

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F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a resident was free from unnecessary medications related to the administration of an as needed (prn) antianxiety medication without interventions attempted first for 1 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria	F 0329	**F329** **The facility requests paper compliance for this citation.** *This Plan of Correction is*	11/27/2016

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	for unnecessary medications. (Resident #153) Finding includes: The record for Resident #153 was reviewed on 10/27/16 at 8:40 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, dementia, psychosis, macular degeneration, major depressive disorder, difficulty walking, and history of falls. The Annual Minimum Data Set (MDS) assessment dated 8/9/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4, meaning the resident was not cognitively intact and was severely impaired for decision making. Physician Orders dated 8/9/16, indicated the resident was to receive Xanax (an antianxiety medication) 0.25 milligrams (mg) prn every 6 hours for anxiety. Nurses' notes dated 10/7/16 at 8:50 p.m.,10/10/16 at 7:43 p.m., 10/14/16 at 9:51 p.m., 10/15/16 at 8:54 p.m., and 10/24/16 at 8:13 p.m., indicated the resident had "anxiety" and the prn Xanax was administered at those times. There was no documentation of what interventions were tried first before		*the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #153 PRN order was placed into the category PRN psychotropic which automatically prompts for the three non-pharmacological interventions prior to allowing staff to administer. **2) How the facility identified other residents:** Medication lists were reviewed for all residents to identify those with PRN psychotropic medication. All residents who were identified as	

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	administering the Xanax. Interview with the Assistant Director of Nursing (ADON) #2 on 10/28/16 at 1:55 p.m., indicated there was no documentation of any interventions tried first before administering the prn Xanax. She indicated the Nurses should have documented what they did in the progress notes. 3.1-48(a)(3)		having PRN psychotropic medications had their PRN orders switched to include the prompts for the three interventions. **3) Measures put into place/ System changes:** Nurses and QMAs were in-serviced on this template and the necessity of documenting the non-pharmacological interventions that were completed. They were also educated on the need to check that the physician or NP used the proper template when entering their orders. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor the documentation and completion of the three interventions and the proper use of the template. Audits will be completed at least 3 times weekly, on all residents with PRN psychotropic medications, and monitored by DON or designee. The results of these audits will be reviewed in Quality Assurance	

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			Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **November 27, 2016**	
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to			

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	exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the staffing pattern was posted daily at the beginning of the shift. Finding includes: On 10/24/16 at 4:30 a.m., the facility staffing sign was not posted at the Main Entrance nor at the 400 unit entrance. The daily staffing sheets were also not observed at any Nurses' station. On 10/25 and 10/26/16 at 8:15 a.m., the facility staffing sign was not posted at the Main Entrance nor at the 400 unit entrance. The daily staffing sheets were also not observed at any Nurses' station. On 10/27/16 at 9:00 a.m., the facility staffing sign was not posted at the Main Entrance nor at the 400 unit entrance. The daily staffing sheets were also not observed at any Nurses' station. On 10/28/16 at 9:50 a.m. the daily staffing sheet was not posted at each Nurses' station. Interview with the Administrator at the time, indicated the	F 0356	**F356** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Nursing staffing data was posted.	11/27/2016

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	staffing sheets were supposed to be posted each morning at each Nurses' station. The Administrator was informed at this time that the staffing sheets had not been visible all week. 3.1-17(a)		**2) How the facility identified other residents:** Any resident wishing to see the data could be affected. **3) Measures put into place/ System changes:** Nursing educated on the completion and posting of the required staffing sheets. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor for correct completion and posting of the staffing data. Audit will be completed five times a week on each unit and monitored by DON or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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			5) Date of compliance: November 27, 2016	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to serve and prepare food under sanitary conditions related to transporting uncovered food from the kitchen, opened boxes of food in the freezer, and opened and undated food in the refrigerator for 1 of 1 kitchen and 2 of 5 dining rooms. (The Main Kitchen and the two 100 Unit Dining Rooms) Findings include: 1. On 10/27/16 at 11:47 a.m., two lunch carts were delivered to the 100 unit dining rooms. There were 2 fruit cups and 12 cakes delivered to the independent dining room and 7 cakes, 6 fruit cups, and 1 pureed cake delivered to the	F 0371	**F371** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared*	11/27/2016

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	assisted dining room uncovered. Interview at the time with the Dietary Manager, indicated the deserts should have been covered before they were transported from the kitchen. Interview with the Director of Nursing on 10/27/16 at 2:07 p.m., indicated the deserts should have been covered prior to leaving the kitchen. 2. During the Initial Kitchen Sanitation tour on 10/24/16 at 5:35 a.m., with Prep Cook #1, the following was observed: a. There were boxes of beef patties, fried chicken, and tater tots in the freezer open to air. b. There was a tray of meatloaf not fully covered in the walk in refrigerator. c. There were two pans of jello uncovered and without a date in the walk in refrigerator. Interview at that time with the Prep Cook, indicated the boxes of food should have been closed in the freezer, and the food should have been covered and dated in the refrigerator. Interview with the Dietary Food Manager on 10/25/16 at 8:23 a.m., indicated the		*and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Food being delivered from the kitchen to the dining rooms are covered. Food stored in the freezer and the walk-in refrigerator was properly dated and covered **2) How the facility identified other residents:** Any resident who receives an oral diet has the potential to be affected. **3) Measures put into place/ System changes:** Dietary educated on the proper method of delivering food from the kitchen and the proper dating and storage of food in the freezers and walk-in refrigerator.	

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	food should have not been open to air in the freezer and left uncovered with no date in the refrigerator. The facility "Food Storage" policy provided by the Administrator was reviewed on 10/28/16 at 2:00 p.m. The policy read that all food products will be covered, identified and dated. 3.1-21(i)(3)		**4) How the corrective actions will be monitored:** An audit tool was devised to monitor for correct delivery and storage of food. Audit will be completed five times a week on varying shifts and monitored by Dietary Manager or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were secured for 2 of 2 residents on the 400 unit and ointments and creams were secured in the treatment cart for 1 of 4 units. (Residents #C and #206 and the 200 unit) Findings include: 1. During a room observation on 10/24/16 at 7:02 a.m.,10:10 a.m., and 11:55 a.m., in Resident #206's room, there were 3 bottles of over the counter medications noted on the resident's bed	F 0431	**F431** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	11/27/2016

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	side table and night stand. There was one bottle of Vitamin C and two bottles of Vision vitamins. During a room observation on 10/24/16 at 8:15 a.m., 10:12 a.m. and 11:53 a.m., in Resident #C's room, there was a bottle of Tums antacid tablets observed on the table. During a room observation on 10/25/16 at 9:40 a.m. and 11:50 a.m., the bottle of Tums tablets was still observed on the table in Resident #C's room. Interview with the Assistant Director of Nursing (ADON) #1 on 10/26/16 at 8:50 a.m., indicated both residents were alert and oriented, however, there was no order for either one of them to self administer their own medications. She further indicated the medications should not have been in their room. Interview with LPN #1 on 10/26/16 at 8:57 a.m., indicated there was no Physician Order for Resident #C to have the Tums tablets. Interview with LPN #2 on 10/26/16 at 9:00 a.m., indicated she was unaware Resident #206 had those medications in her room and there was no Physician Order for the resident to have the		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #206 and Resident #C had medications removed from their rooms. Physicians were notified and orders for the medication were requested. Treatment cart was locked. **2) How the facility identified other residents:** Resident rooms were checked and no other residents had medications in their rooms without orders. No other carts were found unlocked. **3) Measures put into place/ System changes:**	

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	Vitamin C or the Vision vitamins. The current 4/2014 Self Administration of Medication policy was provided by the Administrator on 10/28/16 at 12:24 p.m. The policy indicated a resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending Physician. 2. On 10/24/16 at 4:10 a.m., the 200 unit treatment cart was observed to be unlocked. The contents were visualized with LPN #3 and included bio freeze ointment, aspercreme, hydrogen peroxide and enemas. Interview at that time with LPN #3, indicated the treatment cart should have been locked. Interview with the Director of Nursing (DON) on 10/28/16 at 12:35 p.m., indicated the treatment cart should have been locked. The Guidelines for the Storing of Medication was received from the Administrator on 10/28/16 at 2:00 p.m. The guidelines indicated compartments containing medications were to be locked when not in use. It further noted compartments to include, but were not limited to, drawers, cabinets, rooms,		Staff educated on the policy regarding medications in resident rooms. Staff educated on the need to lock all medication and treatment carts when not in use. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor for correct storage of medication. Audit will be completed five times a week on varying shifts/ units and monitored by Director of Nursing or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** November 27, 2016	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	refrigerators, carts and boxes. 3.1-25(m)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.			

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	155156	A. BUILDING 00 B. WING	10/28/2016

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	(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure systems were in place to prevent the spread of infection related to an ice scoop laying in the cooler, the handling of linens, the storage of urinals and wash basins and soiled incontinent briefs on the floor for 4 of 4 units. (The 100, 200, 300, and 400 units) Findings include: 1. On 10/24/16 at 4:05 a.m., the ice scoop was observed inside the cooler where there was melting ice on the 400 unit. Interview with the Administrator on 10/28/16 at 12:24 p.m., indicated the ice scoop was not supposed to be laying in the bottom of the cooler with the melting ice. The current undated Ice policy provided by the Administrator on 10/28/16 at 12:24 p.m., indicated "ice buckets, other containers, and scoops shall be kept clean and shall be stored and handled in a sanitary manner."	F 0441	**F441** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The ice scoop was removed from the bottom of the ice chest. The urinal was removed from the hand rail in room 301 bathroom.	11/27/2016

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	2. During the Environmental Tour with the Maintenance Director and the Housekeeping Supervisor on 10/28/16 from 9:00 a.m. until 9:30 a.m., the following was observed: 300 unit a. There was a urinal observed on the handrail in the bathroom in room 301. The urinal was not stored in a plastic bag. There were 2 residents who shared the bathroom. b. There was a wash basin observed on the floor under the sink in the bathroom in room 312. The wash basin was not stored in a plastic bag. There were 2 residents who shared the bathroom. Interview with the Maintenance Director on 10/28/16 at 9:30 a.m., indicated the urinal and the wash basins were to be stored in a plastic bag and not on the floor or the hand rails in the bathroom Interview with the Administrator on 10/28/16 at 1:02 p.m., indicated there was no specific policy for the storage of bed pans and urinals, but she would expect them to be stored in a plastic bag when not in use. 3. On 10/24/16 at 4:20 a.m., during the initial tour of the facility, Room 115 was		The wash basin from room 312 was removed from the floor. The wet brief and linens were removed from the floor and discarded properly. CNA #5 was reeducated. CNA#2 was educated on the proper way to carry linens down the hall. **2) How the facility identified other residents:** No other ice scoops were found in the ice chests. All resident bathrooms were checked for improper storage of urinals or wash basins. Rooms were checked for soiled linens or briefs on the floor. Any resident who receives linen that was carried improperly could be affected. **3) Measures put into place/ System changes:** Staff educated on the policy regarding ice scoops and ice chests. Staff educated on the proper storage of urinals and wash basins. Staff educated on the proper way to dispose of soiled briefs and linens. Staff educated on the proper way to carry linens down the hall.	

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	observed. There was a sheet, a blue chux (a sheet protector), and a wet brief wrapped into a bundle on the floor at the entrance of the doorway. Interview at the time with CNA #5, indicated the brief was soiled with urine and the linen, chux, and brief should have been disposed of properly. Interview with the Director of Nursing (DON) on 10/27/16 at 2:07 p.m., indicated the brief and linen should have been disposed of properly. 4. On 10/25/16 at 10:20 a.m., on the 200 unit, a CNA was observed coming out of the linen room carrying clean linen against her body. On 10/25/16 at 10:34 a.m., on the 200 unit, CNA #2 was observed walking down the hallway carrying clean linen against her body. Interview with CNA #2 on 10/25/16 at 10:42 a.m., indicated she was aware she should not carry linens in the hallway against her body. Interview with the Director of Nursing (DON) on 10/28/16 at 11:35 a.m., indicated the CNAs should not be carrying the linen against their body.		**4) How the corrective actions will be monitored:** An audit tool was devised to monitor for correct storage of ice scoops. Audit will be completed five times a week on varying shifts/ units and monitored by Director of Nursing or designee. An audit tool was devised to monitor for the correct storage of urinals, wash basins and the disposal of soiled briefs and linens. Audit tool will be completed on five rooms five times weekly on varying shifts and units and monitored by the Director of Nursing or designee. An audit tool was devised to monitor for carrying linens down the hall in the correct manner. Audit tool will be completed five times a week and monitored by the Director of Nursing or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	The current Infection Control Standard Precautions policy was provided by the DON on 10/28/16 at 12:30 p.m. The policy indicated linens will be handled in a manner which prevented contact with the employee's clothing. 3.1-19(g)(1)		**5) Date of compliance:** November 27, 2016	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to marred and gouged walls, room and bathroom doors, dusty ceiling vents, floor registers with chipped paint, rusty toilet bowls, and dirty floors for 4 of 4 units. (The 100, 200, 300, and 400 units) Findings include: 1. During the Environmental Tour with the Maintenance Director and the Housekeeping Supervisor on 10/28/16	F 0465	**F465** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	11/27/2016

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	from 9:00 a.m. until 9:30 a.m., the following was observed: 100 unit a. There was a hole in the wall above the heat register in room 108. The floor register was rusty and the paint was chipped. There was a brown substance under the light switch. There were brown rust streaks inside of the toilet bowl and the bathroom door was marred. There was 1 resident who resided in the room and 2 residents who share the bathroom. b. The paint was peeling on the paper towel dispenser in room 113. There were 2 residents who shared the bathroom. c. The wall behind the chair was marred in room 110. There was 1 resident who resided in the room. d. The walls were marred in room 102. There was 1 resident who resided in the room. 200 unit a. The closet door was marred in room 207. There was no ring for the toilet paper. There were 2 residents who resided in the room and 4 residents who shared the bathroom.		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The hole in the wall/ gouges were repaired for room 108 above the heat register, room 211, room 234, room 301. The rust and paint chips to the register were repaired for room 108. The wall near the light switch in room 108 was cleaned. The rust streaks were removed from the toilet bowl in rooms 108 and 403. The marring and gouges to the bathroom doors/ frames were fixed for rooms 108, 211, 301,	

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	b. The bathroom ceiling vent was dusty in room 206. There were 3 residents who shared the bathroom. c. The closet doors were marred in room 205. There were 2 residents who resided in the room. d. The walls were marred and gouged in room 211. The bathroom door was marred and the closet doors were marred and gouged. There was 1 resident who resided in the room. e. The walls by the closet and chair were marred and gouged in room 234. There was 1 resident who resided in the room. 300 unit a. The walls were marred and gouged in room 301. The bathroom door frame was marred and gouged. There were 2 residents who resided in the room and 2 residents who shared the bathroom. b. The wall behind the head of the bed was marred and had chipped paint in room 308. The bathroom door was marred and gouged. There was 1 resident who resided in the room. 400 unit		308, 401, 403, and 410. The peeling paint on the paper towel dispenser was fixed for 113. The marring and paint chips to the walls were repaired in rooms 110, 102, 211, 234, 301, and 308. The marring and gouging to the closet doors were repaired in rooms 207, 205, and 211. The ring for the toilet paper was repaired in room 207. The bathroom ceiling vent in room 206 was dusted. The floor behind the toilet in room 407 was cleaned. The walk-in freezer was repaired to remove ice buildup. **2) How the facility identified**	

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	a. The bathroom door was marred in room 401. There was 1 resident who resided in the room. b. The toilet bowl bolt on the right side of the toilet was rusty and dirty in room 403. The bathroom door was marred. There was 1 resident who resided in the room. c. The floor behind the toilet was discolored in room 407. There was 1 resident who used the bathroom. d. The bathroom door was marred in room 410. There was 1 resident who resided in the room. Interview with the Maintenance Director and the Housekeeping Supervisor at that time, indicated the above was in need of cleaning and/or repair. 2. During the Initial Kitchen Sanitation tour on 10/24/16 at 5:35 a.m., with Prep Cook #1, the following was observed: a. There was an accumulation of ice build up on the outside bottom door of the walk in freezer. b. There was an accumulation of ice build up on the ceiling, pipes. and fans upon entering the walk in freezer.		**other residents:** Room rounds were completed to identify any other rooms with environmental concerns. Any resident in a room with environmental concerns could be affected. Any residents with oral intake could be affected by the ice buildup. **3) Measures put into place/ System changes:** Rounds were completed for every resident room in the building and work orders initiated for repairs. Maintenance in-serviced on the need to identify environmental issues while completing other tasks throughout the building. **4) How the corrective actions will be monitored:** An audit tool was devised to identify environmental issues. Audit tool will be completed on five rooms per week under the supervision of Maintenance	

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	Interview at that time with the Prep Cook, indicated the freezer should not have ice built up. Interview with the Dietary Food Manager on 10/25/16 at 8:23 a.m., indicated there should not be an accumulation of ice outside and inside the freezer. Interview with the Maintenance Director on 10/25/16 at 10:49 a.m., indicated the freezer should not have an accumulation of ice on the outside and inside. Interview with the Administrator on 10/28/16 at 1:44 p.m., indicated there should not be ice build up in or outside the freezer. 3.1-19(f)		Director or designee. An audit tool was devised to monitor walk-in freezer for ice buildup. Audit tool will be completed three times weekly at a variety of time under the supervision of the Dietary Manager or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **November 27, 2016**	