STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	04/17/2019

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00289231. This visit was in conjunction with the Investigation of Complaint IN00289231. Complaint IN00289231 - Unsubstantiated due to lack of evidence. Survey dates: April 11, 12, 15,16, & 17, 2019 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 85 SNF: 7 NF: 4 Total: 96 Census Payor Type: Medicare: 16 Medicaid: 66 Other: 14 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 26, 2019	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for annual survey completed on 4/17/19. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Stephanie Allen, HFA, MHA Executive Director Rosebud Village	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 0550		05/17/2019

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	Based on observation, record review, and interview, the facility failed to ensure a Wanderguard bracelet (security bracelet that sets off an alarm and/or locks the door when the resident approaches a door) was not placed on a cognitively intact resident. This affected 1 of 1 resident reviewed for Wandergaurd placement, (Resident 36) Findings include: Resident 36's record was reviewed on 4/15/19 at 10:23 a.m. The record indicated Resident 36 had diagnoses that included, but were not limited to, bipolar disorder, currently in remission, generalized muscle weakness, other specified anxiety disorders, insomnia, depression, nonorganic psychosis, generalized anxiety disorder, personality disorder, mood disorder, and depressive disorder. An Admission Minimum Data Set assessment, dated 2/12/19, indicated Resident 36 was cognitively intact, did not wander, and was independent with walking. A care plan, dated 4/12/19, indicated: "PROBLEM: Resident is at risk for elopement per the Elopement Risk Assessment aeb (as evidenced by) packing up her belongings and stating that she plans to leave the facility due to not receiving medications earlier than they were due. GOAL: Resident will remain safely in the facility through next review. APPROACH: All facility exits secured. APPROACH: Provide 1:1 attention and conversation as needed. Wanderguard per MD order." During an interview, on 4/11/19 at 3:31 p.m. Resident 36 said she now had a wander guard on		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Elopement assessment for resident 36 has been updated. (Attachment A) ·Wanderguard has been removed from resident 36, order for wanderguard discontinued and elopement care plan updated. (Attachment B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents cognitively intact are at risk. ·Elopement assessment audit will be completed by Social Services/Social Service Support Staff to check for accuracy on cognitively intact residents. ·IDT to be in-serviced per Social Service Support by 5/17/19 on wanderguards, elopement. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·IDT to be in-serviced per Social Service Support by 5/17/19 on wander guards, elopement. ·Elopement assessment will be completed by Social Services with all new admissions/readmissions and quarterly according to the	

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	her ankle and said it upsets her because they think she is going to leave, and she only told them she wanted to go home. The wander guard was observed on her left ankle. On 4/15/19 at 11:08 a.m., Resident 36 said they put a wander guard bracelet on her ankle because she made a statement she wanted to go home. During an observation, on 4/17/19 at 4:05 p.m., Resident 36 was observed as she returned from an outing, resident was dressed in street clothes, and wore a Wanderguard on her left wrist. An "Elopement Risk Assessment", dated 4/12/19, indicated: "Resident has the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted - Yes. Resident often requests to go home and/or is searching for home - Yes...Has the resident been assigned a security bracelet - Yes. If the resident is at risk and a security bracelet is NOT assigned, please document why a security bracelet is not needed: Res was calming down after explanation of why and when she could have medication. Will continue to monitor." Progress notes, dated 4/12/19 at 4:45 a.m. indicated Resident 36 was upset because she was requesting a medication that could not be given at this time, and stated: "I am leaving, I am going home." The Director of Nursing Services was notified of the resident wanting to leave the facility. The resident said she does not want to leave the facility, but "I want my medication back". She was monitored for exit seeking. Progress notes, dated 4/12/19 at 7:09 a.m., indicated: "...Resident voiced concern about wearing the wander guard related to elopement		MDS calendar. ·IDT will review/discuss the initiation of wanderguards in clinical meeting. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Wanderguard CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment C) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	

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	risk. This writer explained that since she is alert and oriented and able to walk around the facility freely and is making statements about leaving the facility and was packing her belongings, that made her an elopement risk. This writer explained that her safety is most important at this time...." On 4/16/19, at 3:48 p.m., the Director of Nursing Services indicated Resident 36 is her own Power of Attorney. A physician's order, dated 4/12/19, indicated: "Positioning/Devices: Wanderguard - Check for function Once a day 10:00 p.m. - 6:00 a.m." A policy for "Elopement Prevention and Response Program" was provided by the Nurse Consultant on 4/17/19 at 2:28 p.m., and indicated, but not limited to: "...Elopement Prevention Program: 1. Resident identified to be at risk for elopement will be identified as follows: a. The facility will utilize an ELOPEMENT RISK ASSESSMENT to identify residents at risk to leave the facility unattended....2. Residents at risk for elopement may utilize a security bracelet...Security bracelets are placed on residents appropriately and per manufacturer's instructions...." 3.1-3(t)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			

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	Based on observation, interview, and record review, the facility failed to: A. Ensure a call light was in reach for 2 of 2 residents observed for call light accessibility. (Resident 36 and Resident 301) and B. Ensure 2 of 2 residents reviewed for hydration had water pitchers in their rooms. (Resident 31 and Resident 36) Findings include: A. 1. Resident 31's record was reviewed on 4/15/19 at 9:33 a.m. The record indicated Resident 31 had diagnoses that included, but were not limited to, pain in right shoulder, right sided weakness and paralysis after bleeding in the brain, osteoarthritis, right shoulder, dementia, psychosis, anxiety disorder, chronic pain, rheumatoid arthritis, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, dated 2/6/19, indicated Resident 31 was severely cognitively impaired, required extensive assist of one for personal hygiene, and had impairment on one side of upper and lower extremities in range of motion. During an observation, on 4/11/19 at 10:49 a.m., Resident 31 was lying in bed asking for help. Her call light was on her left side, above her head and she could not reach the end of the call light to push the red button that turned on the call light. During an observation, on 4/17/19 at 10:14 a.m., Resident 31's call light was not in view. CNA 7 entered the room, and when asked where the call light was, CNA 7 said Resident 31 uses it as a phone, then pulled the call light out from under	F 0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Call light clips were replaced for resident 36 and 301. ·Water pitchers were placed in rooms of resident 31 and 36. ·Hydration reviews completed for both resident 31 and 36 to ensure fluid consumption was at a minimum of 1500ml daily. (Attachment D and E) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents residing at the facility have the potential to be affected. ·Audit has been completed by maintenance to ensure all call lights have workable clips in place. ·Facility audit completed by nurse management to ensure all residents, other than residents NPO or on fluid restriction have a water pitcher in place. ·All staff in-service to be completed by 5/17/19 per ED/DNS on call light placement and utilizing call clips to ensure call light remain in place and in reach of each resident, also on placing fresh water pitchers daily on night shift. (Attachment U) What measures will be put into	05/17/2019

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	the folded blanket that was under the resident's left shoulder. The call light had been clipped to the pillow under her left shoulder, and Resident 31 could not reach the call light. A. 2. Resident 301's record was reviewed on 4/16/19 at 11:55 a.m. The record indicated Resident 301 had diagnoses that included, but were not limited to, cellulitis of abdominal wall, adult failure to thrive, generalized muscle weakness, need for assistance with personal care, and rheumatoid arthritis. An Admission Minimum Data Set assessment, dated 4/3/19, indicated Resident 301 was cognitively intact, and had no impairment of both sides of upper extremities. During an observation, on 4/12/19 at 9:22 a.m., Resident 301's call light was draped out of reach over the headboard. Resident 301 asked for a coke, and could not reach her call light, so staff was notified. The Minimum Data Set Coordinator came in, answered the call light, and said she didn't know who didn't place the call light where the resident could reach it. During an observation, on 4/17/19 at 02:12 p.m., Resident 301 was lying in bed and her call light was draped over headboard of the bed, out of the resident's reach. Resident 301 indicated "I forgot to ask staff if they could give it back to me." During an interview, on 4/17/19 at 2:25 p.m., the Nurse Consultant indicated they don't have a policy for call lights. B. 1. Resident 31's record was reviewed on 4/15/19 at 9:33 a.m. The record indicated Resident 31 had diagnoses that included, but were not		place or what systemic changes will be made to ensure that the deficient practice does not recur; ·All staff in-service to be completed by 5/17/19 per ED/DNS on call light placement and utilizing call clips to ensure call light remain in place and in reach of each resident, also on placing fresh water pitchers daily on night shift. ·Care Companions will complete daily rounds in the AM to ensure resident call lights are in place and all residents if indicated have a fresh water pitcher. ·Executive Director will ask Care Companions if call lights in place and fresh water pitcher in place if indicated, daily in Morning Meeting. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Call lights /Water pitcher CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment F) ·If Threshold of 90% is not met,	

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	limited to, pain in right shoulder, right sided weakness and paralysis after bleeding in the brain, osteoarthritis, right shoulder, dementia, psychosis, anxiety disorder, chronic pain, rheumatoid arthritis, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, dated 2/6/19, indicated Resident 31 was severely cognitively impaired, required extensive assist of one for personal hygiene, and had impairment on one side of upper and lower extremities in range of motion. A care plan, dated 5/4/15, indicated a problem for: "At risk for fluid imbalance due to: diuretic use R/T (related to) Heart failure, a-fib (atrial fibrillation where the atrium in the heart quivers), HTN (high blood pressure) and edema. GOAL: Resident will be free from signs and symptoms of fluid volume deficit. APPROACH: Administer medications as ordered. Document and notify MD of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decrease blood pressure, weak/rapid pulse, change in mental status, decreased urine output, abnormal labs, poor skin turgor. Encourage fluids. Labs as ordered. Record intake." During an observation, on 4/11/19 at 11:08 a.m., Resident 31 did not have a water pitcher or cup of any fluids in her room. An observation, on 4/15/19 at 10:53 a.m., indicated Resident 31 was in her bed and no water or other fluids were observed in her room. On 4/16/19 at 3:18 p.m., Resident 31 was observed sitting across from the nurse's station by C and D halls, said she was thirsty and the nurse at the		an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	

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	desk was informed, who got her something to drink. The resident's room was observed and didn't have a water pitcher in it and has not had any fluids at her bedside or on her over bed table any days of the survey. During an interview, on 4/12/19 at 9:38 a.m., CNA 7 indicated pitchers are removed at night to wash them, some residents don't want a pitcher on their over bed table; it takes up room. She said they pass out pitchers with breakfast when they pass coffee. B. 2. Resident 36's record was reviewed on 4/15/19 at 10:23 a.m. The record indicated Resident 36 had diagnoses that included, but were not limited to, bipolar disorder, currently in remission, generalized muscle weakness, other specified anxiety disorders, insomnia, depression, nonorganic psychosis, generalized anxiety disorder, personality disorder, mood disorder, and depressive disorder. An Admission Minimum Data Set assessment, dated 2/12/19, indicated Resident 36 was cognitively intact, did not wander, had no dehydration, and was independent with walking. A care plan, revised 2/27/19, indicated a problem for: "At risk for fluid imbalance due to: Needing assistance with fluids as needed, has had some nausea and vomiting d/t (due to) Chemotherapy, Hx (of) of Delirium, Allergic Rhinitis, Chemotherapy, Hypokalemia. GOAL: Resident will be free from signs and symptoms of fluid volume deficit. APPROACH: Administer medications as ordered. Document and notify MD of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decrease blood pressure, weak/rapid pulse,			

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	change in mental status, decreased urine output, abnormal labs, poor skin turgor. Encourage fluids. Labs as ordered. Record intake." During an interview, on 4/11/19 at 4:08 p.m., Resident 36 indicated she doesn't have a water pitcher and staff will bring you a glass of water if you ask them. During an observation, on 4/15/19 03:15 p.m., Resident 36 was standing in the hall outside her room, and had no water pitcher in her room. She said she could get a drink herself if a water pitcher was in her room. Random observations on 4/11/19, 4/12/19, 4/15/19, and 4/16/19 indicated Resident 36 did not have a water pitcher in her room. During an interview, on 4/16/19 at 3:43 p.m., the Director of Nursing Services indicated they change out the water pitchers each shift, sometimes twice, and they are changed out at night. Residents on a fluid restriction or thickened liquids would not have a water pitcher, or thickened liquids, said she would check on the water pitcher, said Wanda would ask when she wants something to drink, asks for smaller cups, she can hold on to them easier, 3.1-3(v)(1)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes			

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	accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, record review, and interview, the facility failed to provide privacy for 1 resident during incontinence care. (Resident 31) Findings include: Resident 31's record was reviewed on 4/15/19 at 9:33 a.m. The record indicated Resident 31 had diagnoses that included, but were not limited to,	F 0583	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident 31, the privacy curtain is being utilized when care is being provided. How other residents having the potential to be affected by the same deficient practice will be	05/17/2019

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	pain in right shoulder, right sided weakness and paralysis after bleeding in the brain, osteoarthritis, right shoulder, dementia, psychosis, anxiety disorder, chronic pain, rheumatoid arthritis, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, dated 2/6/19, indicated Resident 31 was severely cognitively impaired, required extensive assist of one for personal hygiene, and had impairment on one side of upper and lower extremities in range of motion. A care plan, last revised on 2/21/19, indicated Resident 31 required assistance and/or monitoring for ADL care, with a goal she would have her ADL needs met. On 4/11/19 at 11:08 a.m., CNA 7 was providing incontinence care to Resident 31. LPN 7 left the room with the resident lying in an incontinence brief, and bowel movement on both sides of her and on the bed, and there was no curtain to shield the resident from being seen outside her door when the door was opened. On 4/11/19 at 11:09 a.m., CNA 7 opened the door and re-entered the room; the curtain was not pulled around the bed, and a male voice could be heard outside the door. On 4/11/19 at 11:09 a.m., CNA 9 entered the room to assist with Resident 31. The curtain was not pulled around the bed and the resident was visible when the door was opened. During an interview, on 4/17/19 at 10:07 a.m. the Nurse Consultant indicated privacy is the second thing you do before you perform care, you would talk to the resident, then pull the curtain for		identified and what corrective action(s) will be taken; ·All residents dependent for incontinent care are at risk. ·Skills validation for perineal care will completed with all CNAs per Clinical Educator by 5/17/19. (Attachment G) ·In-service all nursing staff on providing resident privacy during care per DNS/Designee by 5/17/19. What measures will be put into place what systemic changes will be made to ensure that the deficient practice does not recur; ·In-service all nursing staff on providing resident privacy during care per DNS/Designee by 5/17/19. (Attachment U) ·All new hires will be educated on providing privacy while providing incontinent care upon hire, per CEC/Designee. ·Perineal care skills validation will be completed according to the QAPI skills calendar. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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	privacy before you started the task. During an interview, on 4/17/19 at 11:23 a.m., LPN 8 indicated she prefers to have the door closed, and the curtain should be pulled around the bed if the door is opened during resident care. A "Skills Validation - CNA" checklist for perineal care was provided by the nurse Consultant on 4/17/19 at 10:44 a.m., and included, but was not limited to: "Procedure Steps: 1. Verify resident and explain procedure. 2. Provide for privacy...." 3.1-3(p)(4)		·Providing privacy CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment H) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least			

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	30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or			

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	related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to notify the ombudsman of a resident's hospitalization, for 1 of 3 residents reviewed for hospitalization. (Resident 2)	F 0623	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	05/17/2019

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	Findings include: Resident 2's record was reviewed on 4/16/19 at 10:39 a.m. Her diagnoses included but were not limited to, muscle weakness, and aphasia (loss of ability to understand or express speech). Her Quarterly Minimum Data Set (MDS) assessment dated 1/2/19, indicated she was severely impaired in her cognitive daily decision making ability. A progress note for Resident 2 dated 3/9/19 at 12:03 p.m., indicated she had choked on her meal and had been sent to a local hospital for treatment. A progress note dated 3/11/19 at 1:29 p.m., indicated she had returned to the facility. An interview with the Social Service Director on 4/17/19 at 11:02 a.m., indicated the Ombudsman had not been notified of Resident 2's hospitalization on 3/9/19. The Emergency Transfer Notification policy provided by the Corporate Nurse on 4/17/19 at 2:13 p.m., indicated the following: "Purpose of Policy: Provide guidance regarding notification requirements to the ombudsman when an emergency transfer occurs to an acute care setting. Policy: When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable. Copies of the notices must also be sent to the ombudsman, when practicable...." 3.1-12(a)(6)(A)		·The Ombudsman has been notified for residents 2 hospitalization. (Attachment I) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents transferred to the hospital have the potential to be affected. ·Ombudsman was notified of all transfers to the hospital for March 2019 and April 2019. (Attachment I) ·Social Service Support to in-service Social Services on Ombudsman Notification Policy by 5/17/19. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·Social Service Support to in-service Social Services on Ombudsman Notification Policy by 5/17/19. ·Social Services will email Ombudsman monthly of all residents out of the facility for the month and include Executive Director in the email to ensure completion. 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;	

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			·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Ombudsman Notification CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment J) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under			

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	§483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview the facility failed to develop and implement a care plan for a catheter, for 1 of 15 residents review for care plans, (Resident 301). Findings include: The record for Resident 301 was reviewed on 4/17/19 at 11:55 a.m. The diagnoses included, but were not limited to, cellulitis of abdominal wall, adult failure to thrive, essential thrombocythemia, muscle weakness, need for assistance with personal care, rheumatoid arthritis.	F 0656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident 301 has a care plan in place for her catheter. (Attachment K) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents with catheters are	05/17/2019

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	Review of the physician's orders dated 3/27/19, indicated "Cath orders: Change foley catheter and urinary drainage bag as needed for dislodgement, leakage or occlusion, Cath orders: Foley catheter care, nursing, every shift, Cath orders: Foley catheter Size: 10 Fr. 10mL bulb. Empty urinary drainage bag and record output every shift." Review of 14 day scheduled MDS (Minimum Data Set) dated 4/8/19, indicated, "Bladder and Bowel: A. indwelling catheter...". The care plans were reviewed and indicated, no care plan in place for her catheter or catheter care. On 4/17/19 at 4:10 p.m., interview with MDS Coordinator indicated, she was not aware Resident 301 did not have a care plan for her catheter. She indicated that other people have been helping to do the MDS assessments and must have missed completing a care plan for the catheter. The IDT (interdisciplinary team) Comprehensive Care Plan Policy provided by the Corporate Nurse on 4/17/19 at 2:50 p.m., indicated, "Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs..." 3.1-35(a) 3.1-35(b)(1)		at risk of being affected. ·Audit completed on all residents with catheters per nurse management to ensure a plan of care is in place. ·IDT in-serviced per RDCS by 5/17/19 on implementing a catheter care plan for residents with catheters, initiate with order or chart review. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·IDT in-serviced per RDCS by 5/17/19 on implementing a catheter care plan for residents with catheters, initiate with order or chart review. ·Admission charts and orders review will be completed daily in the clinical meeting with care plan implemented per MDS/Designee. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Care Plan CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is	

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			achieved. (Attachment L) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and			

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	quarterly review assessments. Based on observation, interview and record review the facility failed to update a resident's care plan with pressure relieving boots and failed to provide care plan meetings for a resident for 2 of 23 residents reviewed for care planning (Resident 25 and Resident 5). Findings include: 1. Review of the record of Resident 25 on 04/16/19 10:00 AM indicated the resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, Alzheimer's disease,Fracture of unspecified part of neck of right femur, sequela 03/14/2019, reduced mobility, muscle weakness, heart failure, anxiety and unsteadiness on her feet. The wound assessment for Resident 25, dated 4/1/19, indicated the resident acquired a stage two pressure ulcer on her right heel that measured 5 centimeters (cm) by 2.8 cm. The wound was an intact blister that had dissolved. The wound assessment for Resident 25, dated 4/5/19, indicated the resident's right heel wound measured 5 cm by 2.8 stage two. The plan of care for Resident 25, dated 4/1/19, indicated the resident had skin impairment the wound was dark and unstageable. The intervention added 4/17/19 was heel boot on right foot at all times and off during personal care. During an observation and interview on 4/17/19 at 10:13 a.m., LPN 4 provided a pressure ulcer treatment to Resident 25's coccyx. The resident was laying in bed and had one slipper sock on her left foot and no sock on her right foot. The	F 0657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Pressure relieving boots have been added to resident 25 wound care plan. (Attachment M) ·Resident 5 has had a documented care plan with both him and his daughter attended. (Attachment N) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents residing at the facility have the potential to be affected. ·Social Service Support to in-service IDT on Comprehensive Care Plan Policy by 5/17/19. ·Social Service Support to in-service Social Service on procedure: care plan invites (keeping copy), resident notification, completing IDT care plan summary by 5/17/19. ·RDCS to in-service IDT by 5/17/19 on care plan updating. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·Social Service Support to in-service IDT on Comprehensive Care Plan Policy by 5/17/19. ·Social Service to identify residents with scheduled care	05/17/2019

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	resident's calves were on a pillow, the resident's right heel was laying on the bed and the heel was black/brown in color. CNA 5 and CNA 2 indicated the resident use to wear pressure relieving boots, but they did not know what happened to them. LPN 4 instructed the aides to go get some pressure relieving boots and put them on the resident. There were no pressure relieving boots observed in the resident's room. During an interview with the Wound nurse on 4/17/19 at 10:35 a.m., indicated she had implemented pressure relieving boots for Resident 25 as soon as she was made aware that the resident had a pressure ulcer on her right heel. During an interview with the Wound nurse on 4/17/19 at 11:42 a.m., indicated she should have updated Resident 25's pressure ulcer plan of care for the pressure relieving boots and she had not updated it. 2. Resident 5's record was reviewed on 4/15/19 at 11:08 a.m. His diagnoses included but were not limited to, hemiplegia and hemiparesis following a cerebral vascular accident, left hand contracture, muscle weakness, diabetes, inflammatory polyneuropathy, chronic pain, and chronic obstructive pulmonary disease. His Quarterly MDS assessment dated 1/8/19, indicated he was understood and had the ability to understand others. He was cognitively intact in his daily decision making skills. A plan of care for Resident 5 initiated 8/10/18, indicated he needed 24 hour care and would remain in the facility. Interventions included he would be invited and encouraged to participate in his goal setting during care plan meetings. During an interview with Resident 5 on 4/11/19 at 11:41 a.m., he indicated he had never been to any		plans daily in morning meeting, which is overseen by the Executive Director. ·RDCS to in-service IDT by 5/17/19 on care plan updating. ·Care plans to be updated daily in clinical meeting with the reading of orders. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Care Plan Invites/care plan updates CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment 0) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 5/17/19	

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	meetings where the facility discussed his care with him. He hadn't participated in any care plan conferences. During an interview with the Social Service Consultant on 4/16/19 at 11:00 a.m., she indicated the facility held care plan conferences approximately 2 weeks after the MDS completion. Resident 5 should have had a care plan conference in January 2019 but she was unable to locate any documentation the care plan conference had taken place. Social Service staff would be the one to document the care plan conference information but the facility hadn't had a Social Service staff when Resident 5's would have been scheduled in January 2019. Resident 5 was scheduled for a care plan conference on 4/19/19. The Comprehensive Care Plan Policy provided by the Corporate Nurse on 4/17/19 at 11:14 a.m., indicated the following: "Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs. Purpose: Create an organized, resident-centered meeting on a routine basis to improve communication with residents, resident families and/or representative regarding the resident's goals, total health status, including functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, sensory and physical impairments, as well as care and services provided			

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	to maintain or restore health and well-being, improve functional level or relieve symptoms. Improve relationships between resident, families and/or representative, and facility caregivers through understanding of resident's social history, culture and preferences to enhance the resident's life. Procedure: ...Resident, resident's families or others as designated by resident will be invited to care plan review... Prior to the Meeting: ...Care Plan invitation has been given to the resident prior to the meeting time (SS)... During the Meeting: ...SS to complete the IDT Care Plan Summary Observation in Matrix... Following the Meeting: SS to provide summary of meeting to resident/representative upon request if not in attendance...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide nail care for 2 of 3 residents reviewed for Activities Of Daily Living (ADLs). (Resident 31 and Resident 301) Findings include: 1. Resident 31's record was reviewed on 4/15/19 at 9:33 a.m. The record indicated Resident 31 had diagnoses that included, but were not limited to, pain in right shoulder, right sided weakness and	F 0677	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Nail care has been provided for both resident 31 and 301. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	05/17/2019

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	paralysis after bleeding in the brain, osteoarthritis, right shoulder, dementia, psychosis, anxiety disorder, chronic pain, rheumatoid arthritis, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, dated 2/6/19, indicated Resident 31 was severely cognitively impaired, required extensive assist of one for personal hygiene, and had impairment on one side of upper and lower extremities in range of motion. A care plan, last revised on 2/21/19, indicated Resident 31 required assistance and/or monitoring for ADL care, with a goal she would have her ADL needs met. During an observation, on 4/15/19 at 3:05 p.m., Resident 31 sat in a specialized wheel chair in the dining room, her fingernails were long, different lengths and some fingernails had a dark brown substance under the nails. During an observation, on 4/16/19 at 11:38 AM Resident 31 sat in a specialized wheel chair at the nurses' desk, her nails remained long, uneven, and different lengths. On 4/17/19 at 10:14 a.m., Resident 31 indicated her fingernails needed to be filed, she has broken them off. Her fingernails were observed to be different lengths and some of the nails had a dark substance under the nails. CNA 6 and CNA 7 entered the room to take the resident for a shower. On 4/17/19 at 11:17 a.m., Resident 31 said her shower was 'wonderful' and said she didn't know when they would trim her fingernails. Her nails remained long, different lengths, and some of the nails had a brown substance under the nails.		action(s) will be taken; ·All dependent residents have the potential to be affected. ·Audit residents to identify dependent residents per nurse management, providing nail care if indicated. ·In-service Care Companions to note resident nail care when talking to resident daily, per Executive Director by 5/17/19. (Attachment V) ·In-service all staff per DNS/Designee on daily nail care of a dependent resident by 5/17/19. (Attachment U) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·In-service Care Companions to note resident nail care when talking to resident daily, per Executive Director by 5/17/19. ·In-service all staff per DNS/Designee on daily nail care of a dependent resident by 5/17/19. ·Assigned manager will complete weekly walk through on assigned hall noting nail care. 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; ·On going compliance with this	

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	On 4/17/19 at 11:23 a.m., LPN 8 indicated sometimes activities does her nails, the CNA's can trim them, and they are usually done on shower days. She said Resident 31's shower days are Wednesdays and Saturdays. On 4/17/19 at 2:25 PM, the Nurse Consultant indicated they don't have a policy for nail care, so they provided their "Skills Validation" checklist for CNA's. 2. Review on 4/17/19 at 11:55 a.m. of Resident 301's record indicated her diagnoses included, but were not limited to, cellulitis of abdominal wall, adult failure to thrive, essential thrombocythemia, muscle weakness, need for assistance with personal care, rheumatoid arthritis. Review of the physician's orders dated 4/8/19, indicated,"1. Nails cut short weekly with no white part..." Observation on 4/12/19 at 9:25 a.m., indicated, the resident's fingernails had a brown substance around and under her nails. Her nails were different lengths. On 4/16/19 11:52 a.m., observation of Resident 301 in bed watching tv, continues to have brown substance under long fingernails and her toenails are long. An interview with Resident 301 on 4/17/19 at 2:12 p.m., indicated, "the activity person just cut my finger nails for me." Observation of nails indicated they were trimmed short, but continues to have brown substance under nails on both hands, she indicated they did not look at her toenails and her toenails remain long.		corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Care Plan Invites/care plan updates CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	

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	Care plan for ADL's indicated, "Problem: Problem start date: 3/28/19, Resident requires assistance with ADL's...Resident has a desire to maintain current functional status... Nurse to cut nails short per MD order..." Review of a document titled Skills Validation-CNA, provided by the Corporate Nurse on 4/17/19 at 2:28 p.m., indicated,... 9. Clean under nails with orange stick. 10. Clip nails straight across, then file in a curve. 3.1-38(3)(E)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to provide dressing changes twice a day as ordered by the physician for a stage four pressure ulcer and failed to provide a pressure relieving boot for a resident with an unstageable pressure ulcer on her right heel for 2 of 3 residents reviewed for pressure ulcers (Resident 89 and Resident 25).	F 0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident 89 is receiving dressing changes as ordered. (Attachment P) ·Resident 25 was provided	05/17/2019

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	Findings include: 1.) During an interview with Resident 89 on 4/12/19 at 11:44 a.m., indicated the facility nurses do not change her pressure ulcer dressing twice a day like it was ordered by the physician. During an interview with Resident 89 on 4/15/19 at 10:15 a.m., indicated the facility had not been completing the dressing changes twice a day as ordered and she was going to talk with the wound doctor about it. The resident indicated she was very upset that her treatments were not being done twice a day because her wound was severe. Review of the record of Resident 89 on 4/15/19 at 10:25 a.m., indicated the resident's diagnoses included, but were not limited to, calculus of kidney, hydronephrosis with ureteral stricture, reduced mobility, pressure ulcer state 4, severe septic shock, muscle weakness, lack of coordination, hypertension, osteomyelitis, Motor Vehicle Accident (MVA) 16 years old, dysphagia and paraplegia. The wound assessment for Resident 89, dated 2/10/19 at 4:55 p.m., indicated the resident was admitted with a stage 4 pressure ulcer in her perineal area. The wound was 3 centimeters (cm) by 2.5 cm with tunneling of 2 cm. The wound assessment for Resident 89, dated 4/11/19 at 6:32 a.m., indicated the resident had a stage four pressure area in her left groin that tunneled to her left labia. The wound measured 2.5 cm by 4.6 cm with tunneling of 4 cm. The Admission MDS assessment for Resident 89, dated 3/8/19, indicated the resident was		pressure relieving boots. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents with treatment orders have the potential to be affected. ·Audit to identify residents with treatment orders/pressure relieving orders per nurse management and review that completion per order. ·In-service all nursing staff per DNS/Designee by 5/17/19 on following MD orders, signing in EMAR when completed, providing pressure relieving measures for residents as ordered. (Attachment U) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·In-service all nursing staff per DNS/Designee by 5/17/19 on following MD orders, signing in EMAR when completed, providing pressure relieving measures for residents as ordered. ·Administration report specific to treatments will be printed daily with results reviewed daily in clinical meeting, which is overseen by the DNS. How the corrective action(s) will be monitored to ensure the deficient	

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	cognitively intact for daily decision making, she was reasonable and consistent. The resident had no rejection of care. The resident was at risk for pressure ulcers and the resident was admitted with pressure ulcers. Interview with the MDS Coordinator on 4/17/19 at 2:27 p.m., Resident 89 was admitted to the facility on 2/10/19 and discharged to the hospital on 2/20/19 and returned on 3/1/19. The Admission MDS was completed 3/8/19 after she returned from the hospital. The physician order for Resident 89, dated April 2019, indicated the resident was ordered the following: cleanse areas to left groin and left labia with normal saline, pack with wet to moist gauze twice a day and cover with a dry dressing. During an observation on 4/16/19 1:34 p.m., the Wound nurse provided Resident 89's pressure ulcer treatment to the left groin and left labia area. The wound had a hole that tunneled from the Left groin to the left labia. The resident did not have a dressing in place prior to the treatment. The Wound nurse indicated the dressing had come off earlier. Interview with the the nurse consultant on 04/17/19 01:43 p.m., indicated Resident 89 did not have documentation her pressure ulcer dressing was changed twice a day on 2/12/19, 2/19/19, 3/7/19, 3/8/19, 3/27/19, 3/28/19, 3/29/19, 4/5/19 and 4/8/19. The wound had decreased in size and depth and there was no infection. The pressure ulcer is one wound because it tunnels together, but per the wound center they want it measured as two wounds. 2.) Review of the record of Resident 25 on		practice will not recur, what quality assurance program will be put into place; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Treatment CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment Q) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	

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	04/16/19 10:00 AM indicated the resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, Alzheimer's disease,Fracture of unspecified part of neck of right femur, sequela 03/14/2019, reduced mobility, muscle weakness, heart failure, anxiety and unsteadiness on her feet. The Significant Change Minimum Data (MDS) assessment for Resident 25, dated 3/20/19, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of two people for bed mobility. The resident was at risk for developing a pressure ulcer. The wound assessment for Resident 25, dated 4/1/19, indicated the resident acquired a stage two pressure ulcer on her right heel that measured 5 centimeters (cm) by 2.8 cm. The wound was an intact blister that had dissolved. The wound assessment for Resident 25, dated 4/5/19, indicated the resident's right heel wound measured 5 cm by 2.8 stage two. The wound assessment for Resident 25, dated 4/11/19, indicated the wound was unstageable pressure ulcer on her right heel. The area had slough and/or eschar. The area was a blister that reabsorbed the tissue covering the area was brown and firm. The area measured 4 cm by 2.2 cm. During an observation on 4/16/19 at 11:43 a.m., CNA 1 and CNA 2 transferred Resident 25 from the bed to the wheelchair. Resident 25 was laying in bed with slipper socks on her both her feet. The resident did not have any pressure relieving boots in place and her heels were laying on the bed.			

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	During an observation on 4/16/19 at 11:43 a.m., RN 3 provided a pressure ulcer treatment to Resident 25's right heel. The resident's right heel was medium size black/brown tissue. The resident was sitting in her wheelchair with her feet on a foot pedal with slipper socks in place, there were no pressure relieving boots on. During an observation and interview on 4/17/19 at 10:13 a.m., LPN 4 provided a pressure ulcer treatment to Resident 25's coccyx. The resident was laying in bed and had one slipper sock on her left foot and no sock on her right foot. The resident's calves were on a pillow, the resident's right heel was laying on the bed and the heel was black/brown in color. CNA 5 and CNA 2 indicated the resident use to wear pressure relieving boots, but they did not know what happened to them. LPN 4 instructed the aides to go get some pressure relieving boots and put them on the resident. There were no pressure relieving boots observed in the resident's room. During an interview with the Wound nurse on 4/17/19 at 10:35 a.m., indicated she had implemented pressure relieving boots for Resident 25 as soon as she was made aware that the resident had a pressure ulcer on her right heel. The Wound nurse indicated the unit nurse was responsible to ensure the residents pressure ulcer interventions were in place. The skin management program provided by the Nurse Consultant on 4/17/19 at 2:50 p.m., indicated the purpose was to promote the prevention of pressure ulcers/injury development; promote healing of existing pressure ulcers/injuries and prevent development of additional pressure ulcer/injury. "A resident with			

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	a pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing." "Stage 4 pressure injury: Full-thickness skin and tissue loss" . " Undermining and tunneling may occur." "Unstageable pressure injury: obscured full-thickness skin and tissue loss Full - thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar." 3.1-37(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.			

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	§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to have sufficient nurse staffing to ensure residents were provided with nail care, answered call lights timely, and toileting done timely. This had the potential to affect all 96 residents in the facility. (Residents 31, 301,14, 38, 5, and 29) Findings include: 1. Resident 31's record was reviewed on 4/15/19 at 9:33 a.m. The record indicated Resident 31 had diagnoses that included, but were not limited to, pain in right shoulder, right sided weakness and paralysis after bleeding in the brain, osteoarthritis, right shoulder, dementia, psychosis, anxiety disorder, chronic pain, rheumatoid arthritis, and generalized muscle weakness. A Quarterly Minimum Data Set assessment, dated 2/6/19, indicated Resident 31 was severely cognitively impaired, required extensive assist of one for personal hygiene, and had impairment on one side of upper and lower extremities in range of motion. A care plan, last revised on 2/21/19, indicated Resident 31 required assistance and/or monitoring for ADL care, with a goal she would have her ADL needs met. During an observation, on 4/15/19 at 3:05 p.m., Resident 31 sat in a specialized wheel chair in the dining room, her fingernails were long, different	F 0725	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident 31 had her nails cut and cleaned. ·Resident 301 had her fingernails cut and cleaned. Resident 301 had her toenails cut. ·Resident 14, 38, 5 and 29 were met with to ensure needs were met. ·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents have the potential to be affected. ·Audit to identify any residents needing nail care to be completed and those found to need nail care will have nail care completed. ·Audit of all residents to review shower schedules are per preference and are being received; any issues to be immediately rectified. ·Audit of all residents to ensure linens have been changed, any issues to be immediately rectified. ·Audit of all alert and oriented residents to see if any trends with call light timeliness can be identified.	05/17/2019

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	lengths and some fingernails had a dark brown substance under the nails. During an observation, on 4/16/19 at 11:38 AM Resident 31 sat in a specialized wheel chair at the nurses' desk, her nails remained long, uneven, and different lengths. On 4/17/19 at 10:14 a.m., Resident 31 indicated her fingernails needed to be filed, she has broken them off. Her fingernails were observed to be different lengths and some of the nails had a dark substance under the nails. CNA 6 and CNA 7 entered the room to take the resident for a shower. On 4/17/19 at 11:17 a.m., Resident 31 said her shower was 'wonderful' and said she didn't know when they would trim her fingernails. Her nails remained long, different lengths, and some of the nails had a brown substance under the nails. On 4/17/19 at 11:23 a.m., LPN 8 indicated sometimes activities does her nails, the CNA's can trim them, and they are usually done on shower days. She said Resident 31's shower days are Wednesdays and Saturdays. 2. Review on 4/17/19 at 11:55 a.m. of Resident 301's record indicated her diagnoses included, but were not limited to, cellulitis of abdominal wall, adult failure to thrive, essential thrombocythemia, muscle weakness, need for assistance with personal care, rheumatoid arthritis. Review of the physician's orders dated 4/8/19, indicated,"1. Nails cut short weekly with no white part..." Observation on 4/12/19 at 9:25 a.m., indicated, the resident's fingernails had a brown substance		·In-service all nursing staff per DNS/Designee by 5/17/19 on following: nail care, call light protocol, shower schedules, linen changes, and break schedules. (Attachment U) ·In-service of nurse management per ED/Designee by 5/17/19 on appropriate staffing levels and protocol to be completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·In-service all nursing staff per DNS/Designee by 5/17/19 on following: nail care, call light protocol, shower schedules, linen changes, and break schedules. ·In-service of nurse management per ED/Designee by 5/17/19 on appropriate staffing levels and protocol to be completed. ·Care Companion representatives will check nail care, call light timeliness, linen changes, and showers with residents with their daily visits with any issues found to be discussed at Morning Meeting and addressed with GEMBA by nurse management. 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; ·On going compliance with this	

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	around and under her nails. Her nails were different lengths. On 4/16/19 11:52 a.m., observation of Resident 301 in bed watching TV, continues to have brown substance under long fingernails and her toenails are long. Observation on 4/17/19 at 2:12 p.m., of the resident lying in bed, call light was draped over headboard of bed out of resident's reach, she indicated "I forgot to ask staff if they could give it back to me." An interview with Resident 301 on 4/17/19 at 2:12 p.m., indicated, "the activity person just cut my finger nails for me." Observation of nails indicated they were trimmed short, but continues to have brown substance under nails on both hands, she indicated they did not look at her toenails. Toenails remain long. Care plan for ADL's indicated, "Problem: Problem start date: 3/28/19, Resident requires assistance with ADL's including bed mobility, transfers, eating and toileting related to: muscle weakness d/t sepsis secondary to cellulitis of abdomen and iron deficiency anemia d/t blood loss Goal: Resident has a desire to maintain current functional status Approach: start date 4/9/19, Nurse to cut nails short per MD order..." 3. On 4/15/19 at 11:27 a.m., a meeting was held with the Resident Council. 8 out of 11 residents present indicated when they turn on their call lights, staff will come in, turn it off and said they will come back, but they don't come back. Resident 14 indicated he has been told by staff that they are the only person on that hall and they		corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Nail care/call light/shower/staffing CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment R) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	

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	can't help him right then. Resident 38 said she has to wait because she requires a Hoyer lift, and they have to get someone to help because it takes 2, then they have to find the Hoyer lift. Resident 38 said residents aren't getting showers on their shower days; they don't have enough staff. Residents said bed sheets are supposed to be changed on their shower days and they aren't changed. 4. During an interview, on 4/11/19 at 3:01 p.m., Resident 5, who is cognitively intact, indicated they don't have enough staff; it takes forever for someone to answer your call light. This happens all shifts, girls call in and they aren't replaced, it takes 15-20 minutes to answer the call light and they will come in and say they have to help someone else and then they don't come back. He said he had 2 accidents with his bowels while waiting for some one to answer his call light and said "it was bad". He said he goes in the hall to find someone and there isn't any aids to get. Said he has had a bad day so far, it took him an hour to get someone to get him up; he can't get up on his own. A care plan, with a review date of 1/23/19, indicated: "PROBLEM: Self care deficit including bed mobility, transfers, eating, and toilet use related to functional mobility d/t (due to) left sided hemiparesis (weakness) r/t CVA (stroke), L (left) Hand contracture, COPD (chronic obstructive pulmonary disease). GOAL: Resident will be kept clean and odor free. APPROACH: Half laptray on L side of wheelchair for positioning and comfort d/t Hemiparesis-CVA-L hand contracture...Assist of 1-2 with bed mobility. Assist of 1-2 with toileting...Assist of 1-2 with incontinent care as			

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	needed...." A care plan, with a review date of 1/23/2019, indicated a problem for: "Resident is at risk for adverse effects of incontinence related to impaired mobility and need for assist with incontinent care...Resident will be free from adverse effects of incontinence...Assist with elimination: Assist to toilet upon resident request...." 5. On 4/12/19 at 10:50 a.m., Resident 29 indicated call lights take a long time to be answered, an aide will answer it and then leave, and they never see them again. One nurse came in when she turned the bathroom light on and told her to turn it off that her supervisor would see it. She sat 45 minutes one night and no one answered the call light. She said she wrapped her clothes around her legs and wheeled her wheel chair into the hall and asked for help. She further indicated that 2 staff will come in and answer a light and one person helps the resident while the other one sits and talks to the aid who is helping the resident. She has waited an hour and 45 min for pain meds while she was in pain, sometimes when she requests something, she is told the aide or the nurse is doing their charting. There are times when no one is on the floor, the nurse and aides go on break at the same time. Review of the "Resident Census and Conditions of Residents" indicated there are 96 residents in the facility; 22 residents who are dependent on staff for bathing, 50 who require assist of one or two staff for bathing, 66 residents who require assist of 1 or 2 for dressing, 12 who are dependent on staff for dressing, 57 who are require assist of 1 or 2 staff for transferring, 10 who are dependent on staff for transferring, 66 who require assist of 1 or 2 staff for toilet use, 12 who are dependent on staff for toilet use, 25 who require assist of 1 or 2 for eating, and 10 who are dependent on staff for			

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	eating. 77 residents who are occasionally or frequently incontinent of bladder and are on a urinary toileting program, 61 residents who are occasionally or frequently incontinent of bowel who are on a bowel toileting program, and 78 who walk with assistance or assistive devices. A policy for staffing was provided by the Administrator on 4/17/19 at 3:30 p.m. The policy indicated, but was not limited to: "The staffing policy of [Name of company] is to maintain adequate staffing in each facility. 2. The Home Office and Facility Leadership team determines the staffing needs based on occupancy, professional utilization, numbers of halls, number of nursing stations, type of halls (Moving Forward Hall, Vent Hall) and acuity are considered (number of residents with ventilators, number of residents on dementia unit, number of residents on Medicare only units)...6. The Home Office Financial Operations Team compares the actual staffing hours to budget for all disciplines daily." 3.1-17(a)			
F 0825 SS=D Bldg. 00	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services;			

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	or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on record review and interview, the facility failed to ensure a resident who required therapy, received specialized therapy from an outside source for 1 of 3 reviewed for therapy. (Resident 44) Findings include: Resident 44's record was reviewed on 4/15/19 at 11:20 a.m. The record indicated Resident 44 had diagnoses that included, but were not limited to, peripheral vascular disease, chronic pain, open wound of unspecified finger with damage to nail, high blood pressure, and generalized muscle weakness. A Significant Change Minimum Data Set assessment, dated 2/13/19, indicated Resident 44 was cognitively intact, and had no impairment in range of motion in upper extremities. During an interview, on 4/12/19 at 10:16 a.m., Resident 44 indicated he needs therapy in his right hand but isn't getting it. During an interview, on 4/12/19 at 1:30 p.m., Resident 44 indicated he was suppose to be getting a whirlpool and other treatment in therapy, and they were not doing it so when therapy came down today he told them. He further indicated when they checked on the therapy, he was supposed to be getting it done at the wound	F 0825	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident 44 had whirlpool debridement completed. (Attachment S) ·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents with outside therapy orders have the potential to be affected. ·Audit to identify residents with outside treatment orders per nurse management and review that completion per order. ·In-service all nursing staff per DNS/Designee by 5/17/19 on following MD orders and setting up of outside therapy orders. (Attachment u) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·In-service all nursing staff per DNS/Designee by 5/17/19 on	05/17/2019

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	center and it was not set up all week. Physician's orders, dated 4/5/19, indicated: "Hand therapy eval[uation] & tx (treatment), whirlpool debridement". On 4/17/19 at 10:29 a.m., the Therapy Director indicated said she talked to a nurse last Friday and said they don't have the equipment here to do that treatment; they don't have a whirlpool here, and she hasn't heard anything else. On 4/17/19 at 2:04 p.m., the Nurse Consultant indicated they do not have a policy on outside therapy, they were given an order so they should have made a referral for outside services because their therapy does not provide the whirlpool service. 3.1-(a)(2)(b)		following MD orders and setting up of outside therapy orders. ·Administration report specific to orders will be printed daily with results reviewed daily in clinical meeting, which is overseen by the DNS. 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; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Outside therapy CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. (Attachment T) ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; ·Completion date: 5/17/19	