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	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 also included the Investigation of Complaint IN00219738. Complaint IN00219738 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-309 and F-314. Survey dates: February 20, 21, 22, 23, & 24, 2017. Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census bed type: SNF/NF: 86 SNF: 6 Total: 92 Census payor type: Medicare: 7 Medicaid: 63 Other: 22 Total: 92 Sample: 5 This deficiency reflects State findings cited in accordance with 410 IAC	F 0000		

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

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	16.2-3.1. Quality review completed on March 1, 2017			
F 0250 SS=D Bldg. 00	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to assist with discharge planning for 2 of 3 residents reviewed for participation in care planning (Resident F and Resident H). Findings include: 1. Interview with Resident F on 2/20/17 at 12:28 p.m., indicated he did not feel the facility included him on decisions about his medicine, therapy or other treatments. The resident was suppose to come to the facility for therapy and then be discharged. The resident had talked to	F 0250	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **Resident F will have a careplan scheduled by March 26, 2017 to outline scope of treatment and to decide if discharge planning needs to start immediately. If family, POA or guardian cannot attend the careplan will still take place with resident F. If resident F are appropriate for discharge then discharge planning will start**	03/26/2017

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	the facility about his desires to be discharged, but felt like no one wanted to assist him with discharge. The resident had received therapy before and when it was over he was able to go home. During observation and interview with Resident F on 2/23/17 at 2:30 p.m., the resident was standing outside the dining room listening to a live band. The resident smiled and stated "you can't keep a good man down" and then walked independently down the hallway. Review of the record of Resident F on 2/23/17 at 3:33 p.m., indicated the resident's diagnoses included, but were not limited to, alcohol induced dementia, mood disorder, hyponatremia, chronic kidney disease, hypertension, arthritis, anemia and osteoporosis. The Admission care plan conference for Resident F, dated 9/8/16, indicated the resident, the resident's guardian and the Social Service Director attended. The resident's 3 sons were invited and did not show up. The resident reports he was only staying in the facility until he was healed up. "Discussed possible discharge plans and discussed concerns regarding residents drinking." The careplan meeting was rescheduled as the resident's 3 sons did not show up. The careplan meeting		**immediately following the careplan date, with resident input. Resident H had a careplan but was not documented. Insurance dropped resident and resident and family did deny any Medicaid application. Discharge planning needs to be initiated at admission and needs to involve resident, family, POA, guardian, nursing, social services, therapy and physician.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **Audit of careplans to be completed by Social Services of the past year to identify any careplans that have been overlooked or not held due to family, guardian or POA not responding to invitation by March 23, 2017. Any missed careplans will be scheduled immediately. Discharge care planning will start upon admission, collaborating with residents and families as indicated. Careplans will be scheduled within the first week of admission and again in accordance to the MDS schedule, every 64-92 days, unless family or resident requests one earlier or if there is a significant change in the resident's status. If guardian, POA or family do not respond to**	

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	was rescheduled for 9/13/16 at 4:00 p.m. The Quarterly Minimum Data Set (MDS) assessment for Resident F, dated 1/24/17, indicated the resident had the ability to understand others and was able to make himself understood. The resident's decisions regarding tasks for daily decision making was independent and decisions were consistent and reasonable. The resident had symptoms of feeling down, depressed and hopeless, poor appetite or overeating, feeling bad about himself and trouble concentrating. The remainder of the MDS assessment was incomplete. The progress note for Resident F, dated 2/16/17 at 7:12 a.m., indicated the resident was alert and oriented. The resident was independent with Activities of Daily Living (ADL's) and ambulation. The progress note for Resident F, dated 2/23/17 at 3:44 a.m., indicated the resident ambulated through out the facility independently. The resident ate his meals in his room with no help needed. The resident refused assistance with ADL's most of the time. The resident was continent of his bowel and bladder. Interview with the Social Service		**invitation careplan will still be held with the resident when indicated. Correct documentation will be put in the resident's record with the outcome of careplan and direction of care. Individualized careplan will be updated on each resident for scope of care being short term or long term. Discharge planning should be reviewed at least weekly and adjusted as needed, rehabilitation or short term planning.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **New Social Services director in place and will ensure that careplans will be held in a timely manner and will follow MDS schedule after initial careplan, unless there is a significant change or request of resident or resident family, POA or guardian. MDS to share schedule and schedule updates with Social Services director to ensure that careplans are scheduled in a timely manner.** **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Director (S.S.D.) on 2/23/17 at 4:00 p.m., indicated it was the S.S.D. responsibility to set up care plan meetings and assist residents with discharge planning. The S.S.D. had took over this position a week ago and would attempt to find information regarding the facility assisting Resident F with discharge planning and care plan meetings. Interview with Resident F on 2/23/17 at 4:30 p.m., indicated the facility had not talked to him about discharge planning. The resident felt that no one cared if he was at the facility for years. The resident felt it would be different if he was in a wheelchair or something like that, but he was "perfectly capable" of taking care of himself. The resident felt like he wasn't free anymore and served in the military and should be able to do what he wanted. Interview with the S.S.D. on 2/24/17 at 9:37 a.m., indicated the previous S.S.D. had tried to assist Resident F with discharge, as a invite to a careplan meeting had been sent to Resident F's guardian on 1/24/17, and there was no response. There had not been a careplan meeting with Resident 79, since 9/8/16. There was no careplan related to discharge planning. The S.S.D. was going to work with Resident F on the matter of discharging.		**After initial audit of careplan schedule, Social services will audit weekly to ensure no careplans have been missed and that invitations to careplans are sent out in a timely manner to ensure participation. Social Services will schedule careplan within the first week of admission and then according to MDS schedule, every 64-92 days unless there is a significant change or careplan is requested by resident, family, POA or guardian. Social services will ensure that all charting involved with careplans is in place after careplan is held.** *To ensure compliance, the DNS/ designee is responsible for the completion of Resident Care Rounds QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.*	

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	2. Resident H's closed record was reviewed on 2/24/17 at 2:25 p.m. Admission diagnoses, dated 11/17/16, revealed diagnoses that included, but were not limited to, spinal narrowing of the neck region, pressure ulcer, chronic pain, depression, urinary tract infection secondary to chronic indwelling Foley catheter, anemia, heart disease, high blood pressure, congestive heart failure, type 2 diabetes, chronic kidney disease stage 3, and paraplegia (paralysis of the lower trunk and legs). Progress notes, dated 1/8/17 at 9:30 a.m., indicated: "This writer went into res (resident) room to get vitals and res asked about what was going on about him going home on 1/9/17. I told him I would try to get in touch with Social Services. res then started to cry and stated "I should have just killed myself when i got sick. I am just a burden to my children." I told res that his family did not feel that way. I went and found the Executive Director and she stated she would call Social Services. also we have been working on getting a Priest because res would like communion. the Executive Directive will see if can get a Priest to come in today. I started 15 min checks on res. res is in bed at this time with call light within reach. family is in with res at this time and have been told			

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	about the situation." Progress notes, dated 1/9/17 at 7:20 p.m., revealed: "res left facility with [Name of ambulance service] d/c (discharged) to home with home care to [Family member's name]'s house; res and [Family member] both informed of appt (appointment) needed for pcp (primary care physician). 3 day supply of meds sent home with res...." A Significant Change Minimum Data Set assessment, dated 12/8/16, revealed Resident H was cognitively intact, required extensive assistance of 2 for bed mobility, transfers, and toileting, he did not walk, required total dependence of one for dressing, limited assist of one for eating, extensive assist of one for personal hygiene, total dependence on 2 for bathing, and had impairment on both sides of lower extremities in range of motion. On 2/24/17 at 3:55 p.m., the Director of Health Services (DHS) indicated that on 1/6/17, Resident H's insurance company dropped him and the resident and his family declined Medicaid. He went home on January 9th. The DHS said she isn't sure what Social Services did, and the Social Service Director who was here then is no longer here. The Business			

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	Office Manager told her they talked to the family on January the 6th. The DHS said could not find any documentation of any discharge planning. A policy for "Social Services", with a last review date of 11/16, was provided by the Director of Healthcare Services Specialist on 2/24/17 at 12:08 p.m. The policy included, but was not limited to, "It is the policy to provide medically-related social services to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being of each resident including provision of mental health services as ordered by the attending physician...." A policy for Discharge Planning, with a revised date of 12/09, was provided by the DHS on 2/24/17 at 3:00 p.m. The policy included, but was not limited to, "1. It is our policy to ensure that absolutely all patient needs are met prior to discharge from therapy services. 2. It is our goal to facilitate consistent and effective discharge planning. 3. Discharge planning is an interdisciplinary process which includes the rehabilitation team, physician, nursing and other facility support staff in determining goals and assessing whether the patient's needs are being met...Procedure: 1. Planning			

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	for a patient's discharge from rehabilitation is an ongoing process that begins with the initial evaluation and involves the coordination of patient and caregiver support needed to ensure the best longterm functional outcomes after discharge. The discharge plans should be reviewed at least on a weekly basis and adjusted as needed...." 3.1-34(a)			
F 0252 SS=D Bldg. 00	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's			

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	property from loss or theft. Based on observation and interview, the facility failed to maintain 2 hallways and 2 Resident's bedrooms free from urinary odors for 4 of 5 survey days. Findings include: During an initial tour of the facility on 2/20/17 at 7:55 a.m., C and D hallways smelled strong of urine odor. No residents were observed wet. It was not determined what was causing the odor. On 2/20/17 at 10:51 a.m., Resident E's bedroom smelled strong of urine odor. Resident E's clothes appeared dry. It was not determined what was causing the odor. Resident E's bedroom continued to smell of urine odor during observations on 2/22/17, 2/23/17, and 2/24/17. On 2/20/17 at 1:03 p.m., Resident 77's bedroom smelled strong of urine odor. Resident 77's clothes appeared dry. It was not determined what was causing the odor. Resident E's bedroom continued to smell of urine odor during observations on 2/22/17 and 2/23/17. On 2/24/17 at 11:53 a.m., LPN 2 explained she could smell urine odor in Resident E's bedroom at the doorway. Resident E's blue recliner and wheelchair	F 0252	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 77 and resident E's bedrooms were deep cleaned on February 27, 2017 . Resident 77 was provided with a new chair in his room and his wheelchair cushion was replaced. Hallway C and D were deep cleaned on February 27, 2017. No further odors notes. Deep cleaning schedule of resident rooms and hallways will be initiated and followed by housekeeping, and any variance from schedule will be brought to the attention of the IDT in morning meeting. All discharged resident rooms will be deep cleaned the same day resident is discharged. Frequent rounding by Management to ensure that dirty briefs are not left in trash can. Education to staff on inspecting trash cans during rounds and to remove soiled briefs to help with odor will be completed by 3/26/17. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All other residents have the potential to be affected by this alleged deficient practice. Rounds of facility were completed on February	03/26/2017

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	cushion smelled like urine. On 2/24/17 at 12:05 p.m., LPN 2 explained the urine odor in Resident 77's bedroom had probably been coming from his roommate throwing soiled briefs in his trash can. His roommate often changed his own brief and would also spill his urinal on his clothes at times. On 2/24/17 at 12:36 p.m., C hall smelled strong of urine odor. At that time CNA 4 explained C hall smelled like urine because she had just changed a resident's entire bed because it was saturated with urine. The resident would often not allow staff to change her linens and when staff noticed her in the bathroom, they would change her linens at that time. 3.1-19(f)		27, 2017. No other residents/rooms/ hallways were found to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ED/ Designee will conduct a housekeeping inservice on maintaining a safe, clean, comfortable, home like environment by 3/26/17. Room rounds will be completed M-F by Customer Care Reps with a focus put on identifying and correcting odors. A deep cleaning resident room schedule will be initiated by ED/ designee, ensuring each room is deep cleaned monthly and as needed. All hallways will be deep cleaned monthly **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of Environment QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to	

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			ensure compliance and disciplinary action taken as needed.	
F 0272 SS=E Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in			

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	assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. Based on record review and interview, the facility failed to ensure Minimum Data Set assessments were completed and submitted timely for 5 residents. (Residents F, J, B, C, and K) Findings include: 1. Review of the record of Resident F on 2/23/17 at 3:33 p.m., indicated the resident's diagnoses included, but were not limited to, alcohol induced dementia, mood disorder, hyponatremia, chronic kidney disease, hypertension, arthritis, anemia and osteoporosis. The Quarterly Minimum Data Set (MDS) assessment for Resident F, dated 1/24/17, indicated the resident had the ability to understand others and was able to make himself understood. The resident's decisions regarding tasks for daily decision making was independent and	F 0272	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident F, K, B and C MDS's are completed and submitted. Resident J MDS will be completed and submitted by 3/26/17. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by this deficient practice. An audit was completed by RAI specialist on 3/9 to determine other residents who may be affected. All assessments will be completed and up to date for all residents by March 31, 2017. **What measures will be put into place or what systemic changes will be made to ensure that the**	03/26/2017

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	decisions were consistent and reasonable. The resident had symptoms of feeling down, depressed and hopeless, poor appetite or overeating, feeling bad about himself and trouble concentrating. The remainder of the MDS assessment was incomplete. Interview with the Director Of Nursing Services (DNS) on 2/24/17 at 3:15 p.m., Resident F's Quarterly MDS assessment, dated 1/24/17, was not completed.2. Resident J's record was reviewed on 2/21/17 at 2:57 p.m. Diagnoses from the electronic record included, but were not limited to, type 2 diabetes, anemia, high blood pressure, ischemic heart disease, Alzheimer's disease, anxiety, generalized muscle weakness, chronic kidney disease, and pseudobulbar affect. A Significant Change Minimum Data Set (MDS) assessment, dated 1/26/17, failed to have sections G, H, I, J, L, M, and N completed. On 2/24/17 at 3:03 p.m., the Director of Health Services said the MDS was not completed and the date of 1/26/17 was the date it was due to be completed. 3. Review on 2/23/17 at 11:15 a.m., of Resident K's record stipulated, the diagnoses included, but were not limited to, cardiomegaly, congestive heart		**deficient practice does not recur?** Facility has hired a full time MDS Coordinator. MDS Coordinator will provide all appropriate discipline department heads with an assessment schedule weekly and when needed d/t to any schedule changes. Assessment schedule will be reviewed by IDT Monday through Friday during clinical meeting to ensure all assessments are completed and submitted timely. **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the MDS Accuracy – Medicare/ PPS QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	failure, hypertension, depression, anxiety and dementia. Minimum Data Set (MDS) assessment dated 1/4/17 Significant Change in Status, was in process and not completed for section G, H, I, J, L, M, N, P, V and X . 4. Resident B's record was reviewed on 2/22/17 at 8:30 a.m., indicated the diagnoses included, but were not limited to, dementia, in other diseases, classified elsewhere with behavioral disturbance, infection of continent stoma of urinary tract, syncope and collapse, retention of urine, unspecified, Down Syndrome, unspecified, osteoarthritis, unspecified site. MDS assessment dated 1/27/17, Significant Change in Status, was in process and not completed for section G, GG, H, I, J, L, M, N, V and X. 5. Review of Resident C's record on 2/23/17 at 12:45 p.m., stipulated diagnoses included, but were not limited to, unilateral osteoarthritis, right hip, aftercare following joint replacement surgery, hypertension, Borderline Personality disorder, idiopathic gout, unspecified site, Schizophrenia, unspecified, unspecified glaucoma			

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	MDS admission assessment dated 1/17/17, was in process and not completed for section G,GG, H, I, J, L, M, N, and X. 2/24/17 1:11 p.m., interview with Director of Nursing Services stated "the MDS for Resident K dated 1/4/17, the MDS dated 1/27/17, for Resident B and the MDS for Resident C dated 1/17/17, has not been completed or submitted to the state agency yet." 3.1-31(a)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the			

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

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	(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 observation, interview, and record review, the facility failed to care plan the use of an assist bar on a resident's bed that had been placed towards the foot of the bed (Resident I), and failed to care plan a resident's discharge from the facility. (Resident F) This affected 2 of 25 residents reviewed for care plans. Findings include: 1. On 2/20/17 at 11:05 a.m., Resident I was observed lying on his bed and had an assist bar (a narrow bar attached to the side of a bed, near the head of the bed, so a resident can hold on to it while rising) on the open side of his bed. The assist bar was near where the resident's knee is when he is laying down. He swung his legs up over the assist bar and sat up on the side of the bed. He said he could lay down, then demonstrated he could lay down by swinging his legs back and up over the assist bar. The other side of his bed was against the wall. On 2/22/17 at 9:50 a.m., Resident I's bed was observed to have the assist bar 2/3	F 0279	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Assist bar was removed from Resident I's bed as indicated. Assist bar not indicated for this resident. SS scheduled a care plan with resident F **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who utilize assist bars or side rails have the potential to be affected by this alleged deficient practice. An audit was completed on February 27, 2017 of all rooms to identify beds with assist bars/ side rails in place. IDT visited all resident rooms utilizing these adaptive devices to ensure placement was appropriate. Care plans for these residents were reviewed to ensure adaptive devices were included on resident's plan of	03/26/2017

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	down the bed towards the foot of the bed. Resident I's record was reviewed on 2/22/17 at 9:54 a.m. Current physician's orders revealed diagnoses that included, but were not limited to, depression, anemia, Alzheimer's dementia with behavioral disturbances, and high blood pressure. Diagnoses from a local hospital History and Physical indicated diagnoses of blindness in left eye, benign prostatic hypertrophy, and hypercholesterolemia. Physician's orders indicated an order that he may be up ad lib (by himself when he wants). On 2/24/17 at 10:15 a.m., the assist bar was still in place towards the foot of his bed. On 2/24/17 at 11:38 a.m., the assist bar was observed with the Alzheimer's Unit Coordinator. The resident was lying in bed, then sat up, bent his knees and swung his feet around the bar so he could sit up on the side of the bed. He said he didn't use the bar, and the Unit Manager said it looked like his bed was the wrong way, that the assist bar should have been towards the head of the bed The resident said he slept this way and pointed to head of the bed, where his pillow was, at the other end from the assist bar.		care. No other residents were found be affected by this alleged deficient practice. *All residents discharging from facility have the potential to be affected by this deficient practice. SSD will be re-educated by the SS Consultant regarding appropriately care planning resident's discharges, and including residents in discussions regarding discharge planning when indicated*. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Therapy will assess residents currently utilizing assist bars or side rails to determine the most appropriate use of assistive device by 3/26/17. Therapy or designee will provide education to nursing staff on appropriate placement of assist bars and side rails by 3/26/17. DNS or designee will ensure that an Adaptive Device Review is completed prior to initiation of side rails/ assist bars. DNS/ designee will ensure care plan and resident profiles are updated with these adaptive devices. Customer Care Reps will use resident profiles during resident room rounds Monday - Friday, and ensure items are in place.	

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	On 2/24/17 at 12:08 p.m., the Director of Health Services Specialist provided a quality assurance tool for side rails as their policy and said they assess for the use of side rails but not the assist bars. An admission fall risk assessment, dated 2/3/17, indicated Resident I had had no falls within the previous 6 months, and had a total fall risk score of 4 points to indicate a low fall risk. A care plan, dated 2/9/17, indicated a problem for: "Resident is at risk for fall due to: age >65, dementia, impaired tissue perfusion, vision impairment. Goal: Resident fall risk factors will be reduced in an attempt to avoid significant fall related injury. Approaches: Call light in reach. Environmental changes: new environment for resident, been inpatient psychiatric floor. Non skid footwear. Personal items in reach. Therapy screen." 2. Interview with Resident F on 2/20/17 at 12:28 p.m., indicated he did not feel the facility included him on decisions about his medicine, therapy or other treatments. The resident was suppose to come to the facility for therapy and then be discharged. The resident had talked to the facility about his desires to be discharged, but felt like no one wanted to assist him with discharge. The resident		**How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Care Plan Updating QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed. *To ensure compliance, the ED/ designee is responsible for the completion of Discharge Planning QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.*	

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	had received therapy before and when it was over he was able to go home. Review of the record of Resident F on 2/23/17 at 3:33 p.m., indicated the resident's diagnoses included, but were not limited to, alcohol induced dementia, mood disorder, hyponatremia, chronic kidney disease, hypertension, arthritis, anemia and osteoporosis. The Quarterly Minimum Data Set (MDS) assessment for Resident F, dated 1/24/17, indicated the resident had the ability to understand others and was able to make himself understood. The resident's decisions regarding tasks for daily decision making was independent and decisions were consistent and reasonable. The resident had symptoms of feeling down, depressed and hopeless, poor appetite or overeating, feeling bad about himself and trouble concentrating. The remainder of the MDS assessment was incomplete. Interview with Resident F on 2/23/17 at 4:30 p.m., indicated the facility had not talked to him about discharge planning. Interview with the Social Service Director (S.S.D.) on 2/24/17 at 9:37 a.m., indicated there was no careplan related to discharge planning for Resident F. The			

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	S.S.D. was going to work with Resident F on the matter of discharging. The Interdisciplinary Team (IDT) care plan review policy provided by the Director Of Nursing Services (DNS) specialist on 2/24/17 at 12:08 p.m., indicated it was the policy of the facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. "The care plan will included measurable goals and resident specific interventions based on the 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) 3.1-35(b)(2)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including			

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	but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-			

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	(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 quarterly review assessments.			
	Based on observation, interview and record review, the facility failed to develop individualized interventions to address urinary incontinence odors and failed to provide a plan of care meeting timely, for 2 of 27 residents reviewed for	F 0280	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** An appropriate toileting program was initiated for resident E as indicated. Care plan and resident	03/26/2017

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	care plans. (Resident E and F) Findings include: 1. Resident E's record was reviewed on 2/22/17 at 10:22 a.m. Her annual Minimum Data Set (MDS)assessment dated 10/27/16, included she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 1 person for dressing , toileting, and personal hygiene. She was frequently incontinent of her bladder and wasn't on a toileting program. Resident E's diagnoses documented on her February 2017 physician's recapitulation orders included but were not limited to, history of a stroke, diabetes mellitus, history of urinary tract infections (UTI's), and overactive bladder. A plan of care for Resident E specified she was incontinent of her bladder related to impaired mobility, bladder spasms, diabetes mellitus, and a history of UTI's. Her goal included she would be free from adverse effects of incontinence. The approaches to manage her incontinence included assessing and documenting her skin condition weekly. She would be		profile were updated accordingly. SS scheduled a care plan for resident F **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** *All residents have the potential to be affected by this alleged deficient practice. SSD Consultant will complete audit of all residents to identify any other residents affected and care plan meetings will be offered to residents and families as indicated.* *SSD will be re-educated by SSD Consultant by 3/26/17 on setting up care plan meetings timely with residents and families as indicated.* All residents with incontinent episodes have the potential to be affected by this alleged deficient practice. IDT will complete IDT Continence Reviews for all residents by March 10, 2017 and ensure Toileting Programs/ interventions are placed as indicated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** 3 day bowel and bladder assessments will be initiated on admission/ readmission/ change in continence/ and as needed. DNS or designee will complete an IDT	

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	assisted with elimination. She would be assisted with incontinent care as needed. She would be checked every 2 hours for incontinence. Any abnormal findings would be documented and reported to the MD. She would be observed for signs and symptoms of a UTI. On 2/20/17 at 10:48 a.m., Resident E's bedroom smelled strong of urine odor. Resident E's clothes appeared dry. She explained she had the sensation when she needed to urinate. She wore a brief and transferred herself to the toilet. It was not determined what was causing the odor. Resident E's bedroom continued to smell of urine odor during observations on 2/22/17, 2/23/17, and 2/24/17. On 2/22/17 at 10:00 a.m., Resident E explained she was not incontinent of urine and denied urinating in her brief. She explained again she had the sensation when she needed to urinate, she wore a brief, and transferred herself to the toilet. On 2/22/17 at 10:17 a.m., LPN 3 explained Resident E took herself to the bathroom with the use of a rollator or wheelchair. Resident E was incontinent of urine at times. Resident E was a heavy sleeper and incontinent of urine sometimes at night. Resident E was not on any type of toileting program and		Continence Review once 3 day B/B is completed, and an appropriate toileting program and/ or interventions will be placed. IDT to evaluate toiling program weekly times 4 weeks then monthly to ensure proper program in place and no change in continence. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Bladder Program QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed. *To ensure compliance, the ED/ designee is responsible for the completion of Discharge Planning QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting, overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary*	

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	when she urinated on herself it was usually due to urgency; when she headed to the bathroom it would be to late. On 2/22/17 at 10:46 a.m., LPN 3 explained Resident E had skid strips on the floor in front of her toilet but they had come off due to getting wet with urine. When Resident E urinated on the bathroom floor it was due to urgency while lowering her slacks. On 2/23/17 at 9:23 a.m., Resident E was observed toileting herself in her bathroom adjoined to her bedroom. She propelled her wheelchair into the bathroom and transferred herself to the toilet and back to her wheelchair. After toileting she cleaned herself with toilet paper. She voiced she wasn't going to wash her hands because she had gloves on. Resident E was wearing a pair of black exercise type gloves to protect her hands when she propelled her wheelchair. On 2/23/17 at 9:41 a.m., Certified Occupational Therapy Assistant (COTA) 5 explained she had smelled urine odor in Resident ' bedroom on 2/22/17. At that time COTA 5 had asked Resident E if she had an incontinent episode. Resident E had voiced she had during the night. Resident E had voiced that was her first time. It was difficult to get Resident E to		*action taken as needed.*	

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	remove her gloves to wash her hands. On 2/24/17 at 11:53 a.m., LPN 2 explained she could smell urine odor in Resident E's bedroom at the doorway. Resident E's blue recliner and wheelchair cushion smelled like urine. At night Resident E hid her blue jeans wet with urine from staff or she hung them on the back of her chair wet with urine and refused to let staff take them; saying they were dry. She let the blue jeans dry overnight and then put them on again the next day. At that time LPN 2 checked on Resident E in her bathroom and said Resident E's brief was wet with urine, the back of her blue jeans were wet, and she had urine on the bathroom floor. Resident E was wet clear down to her socks. Resident E had denied having a wet brief or wet jeans. LPN 2 had made Resident E's bed that morning and her bedroom hadn't smelled as strong of urine at that time. 2. Interview with Resident F on 2/20/17 at 12:28 p.m., indicated he did not feel the facility included him on decisions about his medicine, therapy or other treatments. The resident was suppose to come to the facility for therapy and then be discharged. The resident had talked to the facility about his desires to be discharged, but felt like no one wanted to assist him with discharge. The resident			

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	had received therapy before and when it was over he was able to go home. Review of the record of Resident F on 2/23/17 at 3:33 p.m., indicated the resident's diagnoses included, but were not limited to, alcohol induced dementia, mood disorder, hyponatremia, chronic kidney disease, hypertension, arthritis, anemia and osteoporosis. The Admission care plan conference for Resident F, dated 9/8/16, indicated the resident, the resident's guardian and the Social Service Director attended. The resident's 3 sons were invited and did not show up. The resident reports he was only staying in the facility until he was healed up. "Discussed possible discharge plans and discussed concerns regarding residents drinking." The careplan meeting was rescheduled as the resident's 3 sons did not show up. The careplan meeting was rescheduled for 9/13/16 at 4:00 p.m. The Quarterly Minimum Data Set (MDS) assessment for Resident F, dated 1/24/17, indicated the resident had the ability to understand others and was able to make himself understood. The resident's decisions regarding tasks for daily decision making was independent and decisions were consistent and reasonable. The resident had symptoms of feeling			

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	down, depressed and hopeless, poor appetite or overeating, feeling bad about himself and trouble concentrating. The remainder of the MDS assessment was incomplete. Interview with the Social Service Director (S.S.D.) on 2/23/17 at 4:00 p.m., indicated it was the S.S.D. responsibility to set up care plan meetings. The S.S.D. would look for any careplan meetings for Resident F. Interview with the S.S.D. on 2/24/17 at 9:37 a.m., indicated there had not been a careplan meeting with Resident F, since 9/8/16. The Interdisciplinary Team (IDT) care plan review policy provided by the Director Of Nursing Services (DNS) specialist on 2/24/17 at 12:08 p.m., indicated it was the policy of the facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. "The care plan will included measurable goals and resident specific interventions based on the resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs." The care plan review will be completed at a minimum			

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	of 90 days. "The resident, resident's families or others as designated by resident will be invited to care plan review." "The care plan problems, goals and interventions will be updated based on changes in the resident assessment/condition, resident preferences or family input." 3.1-35(d)(2)(B)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

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	(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. A. Based on interview and record review the facility failed to assess a Peripherally Inserted Central Catheter (PICC line) every shift as careplanned and failed to complete an ongoing assessment of a resident who had experienced a change in condition of a high fever for 1 of 5 residents reviewed for assessments (Resident A). B. Based on interview and record the facility failed to have ongoing communication with the dialysis center and complete daily weight as ordered by the physician for 1 of 1 resident's reviewed for dialysis (Resident G). Findings include: A. 1. Review of the record of Resident A on 2/21/17 at 2:50 p.m., indicated the resident's diagnoses included, but were not limited to, osteomyelitis of multiple sites, paraplegia and functional urinary incontinence. The record of Resident A, indicated the resident's admission date to the facility was 12/5/16.	F 0309	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident A has discharged from this facility. DNS contacted Dialysis Treatment center for resident G to request ongoing communication be consistent between Dialysis and the facility. Weight was obtained for resident G and documented in his medical record. MD order in place to obtain daily weights for resident G. Form created to ensure proper communication between facility and dialysis center which includes but not limited to: medication changes, labs with results, weight that morning and any changes in condition since last dialysis treatment. Continue with current form for dialysis to communicate with facility with the weight prior to and after and if any medications were given. Inservice to all nursing staff on dialysis observation and importance of filling out observation before resident leaves facility and when resident returns will be completed by 3/26/17. Flow sheet was initiated in front of MAR to	03/26/2017

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	The careplan for Resident A, dated 12/6/16, indicated the resident had an Intravenous (IV) access, double lumen PICC line in the right upper arm and was at risk for infections and complications. The interventions included, but were not limited to, "assess for complication from IV (localized infection, systemic infection, electrolyte imbalance, air embolus, dislodgement, infiltration,, phlebitis, fluid overload, dehydration) every shift. The progress note for Resident A dated, 12/6/16 at 8:29 a.m., indicated the PICC line IV site had no redness or warmth and the dressing was clean, dry and intact. The progress note for Resident A dated, 12/7/16 at 5:44 a.m., indicated the PICC line patent and flushed with ease. The progress note for Resident A dated, 12/10/16 at 8:06 a.m., indicated the PICC line flushed with ease. The documentation indicated no further assessments of the PICC line. The vital signs for Resident A, dated 12/11/16 at 2:47 a.m., indicated the resident's temperature was 104 degrees Fahrenheit (F), 12/11/16 at 3:18 a.m., the resident's temperature was 102.4 degrees F and on 12/11/16 at 3:43 a.m., the resident's temperature was 101.4 degrees		monitor dialysis site, BP every shift for 72 hours after dialysis, daily weight and fluid restriction. Flow sheets, fluid restriction, dialysis observation and dialysis communication book to be monitored daily by unit manager/ designess. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with PICC lines have the potential to be affected by this alleged deficient practice. DNS reviewed MD orders for all residents with PICC lines on February 27, 2017 to ensure orders are in place to assess PICC line every shift. No other residents were found to be affected. All residents who receive dialysis have the potential to be affected by this alleged deficient practice. No other residents receive dialysis in this facility at this time. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nurses will be re-educated on sending Communication Forms to all of resident's dialysis appointments, documenting assessment of resident prior to appointment and upon	

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	F. The event report for Resident A, dated 12/12/16 at 7:51 a.m., indicated the resident had a temperature of 102 and was unstable and likely to get worse. The physician ordered the resident to be sent to the local emergency room for treatment and evaluation. The documentation indicated there were 28 hours and 8 minutes that Resident A was not assessed for a change in condition of a high fever. The local hospital assessment and plan for Resident A, dated 12/12/16, indicated the resident blood pressure was 96/55 and temperature was 103. "We will do a blood culture of the PICC line." The local PICC line culture for Resident A, dated 12/12/16, indicated the result value was "Acinetobacter baumannii" (bacterial infection). The local hospital PICC line culture for Resident A, dated 12/15/16, indicated the result value was "Enterococcus faecium" (bacterial infection). The local hospital discharge orders for Resident A, dated 12/19/16, indicated the primary diagnoses was "polymicrobial bacteremia secondary to infected PICC		return, and obtaining daily weights as ordered by 3/26/17. Dialysis will complete Communication Form to notify facility of any issues that arise during dialysis and return the form with resident. DNS requested for Dialysis to send the facility the resident's Run Sheets weekly. DNS/ designee will request these weekly if facility does not receive as requested. IDT will review daily weights Monday – Friday in clinical meeting to ensure they are obtained. ***Nurses will be re-educated on PICC lines and assessing PICC/ IV sites q shift and notifying MD/NP of any abnormal findings. IDT will review all new admits with PICC/IV's on the next business day to ensure all appropriate orders are in place. Omni provided PICC line care, flush and placement standing orders for all PICC lines unless indicated differently by physician or referring hospital.*** **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Dialysis Care QAPI	

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	line". The facility physician progress note for Resident A, dated 12/20/16, indicated the resident was readmitted to the facility with a diagnosis of "sepsis by PICC line". Interview with the Director Of Nursing Services (DNS) on 2/23/17 at 9:20 a.m., indicated 12/11/16 at 3:43 a.m., was the last assessment of the high fever completed for Resident A until the resident was sent to the emergency room on 12/12/16. Interview with Medical Director on 2/23/17 at 10:46 a.m., indicated Resident A was admitted to local hospital for sepsis of the PICC line, but he believed the sepsis occurred during the actual procedure of the PICC line placement prior to admission to the facility and not from nursing care at the facility. Interview with the DNS on 2/24/17 at 12:27 p.m., indicated there were no further assessments of Resident A's PICC line, except 12/6/16, 12/7/16 and 12/10/16. This indicated the resident's assessments of the PICC line were not completed 15 times. The "resident change of condition" policy provided by the DNS on 2/23/17 at 9:40		tool and the IV/ PICC QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	a.m., indicated all assessment information would be documented in the medical record. B. 1. Review of the record of Resident G on 2/23/17 at 1:59 p.m., indicated the resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes, anxiety, depression, Chronic Obstructive Pulmonary Disease (COPD) and obesity. The physician order for Resident G, dated January 2017 and February 2017, indicated the resident was to receive dialysis every Monday and Friday at the local dialysis center and was to have daily weights. The careplan for Resident G, dated 1/19/16, indicated the resident was receiving hemodialysis and was at risk for complications such as fluid imbalance. The interventions included, but were not limited to, observe for signs of fluid volume deficit such as weight loss and fluid volume excess such as weight gain. The dialysis binder for Resident G, had communication forms with resident's weights pre and post dialysis, any issues or unusual occurrences and medication/treatments given. The binder			

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	had a communication form for September 2016 and January 27, 2017. There were further communication forms from Sept 2016 to February 2017. Review of Resident G's weights for, January 2017, indicated the resident had 2 documented weights, indicating the resident was not weighed 29 times as ordered by the physician. Review of Resident G's weights for, February 2017, the resident had 7 documented weights, indicating the resident was not weighed 8 times as ordered by the physician. Interview with the LPN 1 on 2/23/17 at 2:40 p.m., indicated she was unsure why the communication forms were not being filled out for Resident G. The third shift CNA was responsible to do Resident G's daily weights and the third shift nurse should ensure the weights were completed. The facility did not send information with Resident G to her dialysis appointments. Interview with the DNS on 2/23/17 at 4:05 p.m., indicated the Unit Manager was responsible to over see the communication between the facility and the dialysis center.			

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	Interview with the DNS on 2/24/17 at 11:45 a.m., the nurses did not do the events per policy for Resident G and they were aware this was suppose to be done. The "Dialysis care" policy provided by the Executive Director on 2/23/17 at 3:45 p.m., indicated it was the policy of the facility to ensure that the resident is rendered necessary services for the provision and maintenance of dialysis services through effective communication with the dialysis unit. The nurse in charge at the time of transfer to dialysis will provide the resident with all appropriate paperwork and a dialysis event would be initiated in the Electronic Medical Record (EMR). This Federal tag related to Complaint IN00219738. 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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			

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	hygiene. Based on observation, interview and record review, the facility failed to ensure a resident's fingernails were kept trimmed and clean for 1 of 1 Resident reviewed for Activity's of Daily Living (ADL's). Resident 77. Findings include: Resident 77's record was reviewed on 2/24/17 at 1:33 p.m. His quarterly Minimum Data Set (MDS) assessment dated 11/1/16, specified he was understood and he had the ability to understand others. He required extensive assistance of 1 person for personal hygiene. Resident 77's diagnoses documented on his February 2017 physician's recapitulations orders included but were not limited to, Alzheimer's dementia and generalized anxiety. A plan of care for Resident 77 specified he required assistance and/or monitoring for his ADL care. His goal was to have his ADL needs met. His approaches included assistance with bathing. On 2/20/17 at 1:01 p.m., Resident 77 was observed with jagged fingernails with a dark substance underneath all nails. His	F 0312	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Staff attempted to provide resident 77 with nail care on February 24, 2017 and resident refused care as per progress note. Resident 77's nails were trimmed on February 26, 2017. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. All residents were observed by IDT to determine if nail care was needed and this care was provided when indicated on February 27, 2017. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff will be educated by DNS/ designee on providing nail care daily when indicated by 3/26/17. Customer Care Reps will conduct room rounds Monday – Friday during which they will focus on resident fingernails and notify nursing when nail care is needed.	03/26/2017

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	fingernails were different lengths and his two thumb nails were very long. Resident 77 continued to be observed with his nail appearance the same on 2/22/17, 2/23/17, and 2/24/17. On 2/24/17 at 1:31 p.m., LPN 6 explained the nurses were responsible to trim Resident 77's fingernails because he was a diabetic. The CNA's could clean Resident 77's fingernails and should be part of his daily bathing care. Resident 77 needed some of his fingernails trimmed and he needed his fingernails cleaned. 3.1-38(a)(2)(A)		**How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Environment QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (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			

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	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 have a dressing on a resident's pressure ulcer, failed to follow the physician's order for the correct pressure ulcer treatment, and the nurse failed to wash her hands prior to a pressure ulcer dressing change, for 1 of 3 residents reviewed for pressure ulcers. (Resident D) Findings include: Resident D's record was reviewed on 2/22/17 at 9:41 a.m. Her diagnoses documented on her admission physician's orders signed 2/18/17, included but were not limited to, post open reduction internal fixation of her right hip, degenerative joint disease, and osteopenia. Observation history documentation for Resident D dated 2/17/17 at 6:58 a.m., included a pressure ulcer on her coccyx that measured 1.5 centimeters (cm) long by 1.5 cm wide. No depth could be	F 0314	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident D's treatment orders were reviewed for accuracy. Treatment was provided for resident as ordered. No adverse effects noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All resident with pressure wounds and treatment orders in place have the potential to be affected by this alleged deficient practice. DNS observed all residents with treatment orders on 3/13/17 to ensure correct treatment was in place. DNS observed residents with pressure wounds dressing changes to ensure proper dressing change technique was used on 3/13/17. No other residents were found to be affected by this alleged deficient practice.	03/26/2017

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	measured. The wound was identified on 2/17/17 at 6:58 a.m., and was present on admission. Observation history documentation for Resident D dated 2/17/17 at 3:00 p.m., included a pressure ulcer on her sacrum that measured 5 cm long by 5 cm wide by 0.1 cm deep. The wound had been identified on 2/17/17 at 3:00 p.m., and was present on admission. A physician's order for Resident D dated 2/20/17 at 8:11 a.m., included the following. Calmeseptine applied to her buttock 2 times a day. Her coccyx wound would be cleaned with wound wash, santyl applied, and gauze secured with an island dressing daily and as needed. Her sacrum wound would be cleaned with wound wash, and collagen applied every other day. A plan of care for Resident D specified she had a pressure ulcer on her sacrum and coccyx. An approach to healing the pressure ulcers included she would be provided treatments as ordered by the physician. Resident D was observed receiving a dressing change by LPN 7 on 2/22/17 at 1:57 p.m. CNA 8 was assisting LPN 7 by holding Resident D on her left side.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nurses will be re-educated on Correct Dressing Change procedure, appropriate hand hygiene, and following physician's orders for wound treatments by 3/26/17. Dressing Change Skills Validations will be completed for all nurses by 3/26/17. DNS/ designee will ensure wound care supplies are available for nursing when treatment orders are changed by MD. IDT will review all new MD orders Monday through Friday during clinical meeting to ensure treatment orders are accurate. CNA's will be re educated on importance of informing nurse if dressing comes off during care so that dressing can be reapplied by 3/26/17. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Wound Management QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of	

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	Resident D's brief was unfastened. Resident D had a pressure ulcer on her right inner buttock approximately 3 inches long and different widths along the wound. The wound bed was red and was actively bleeding. Resident D had a hole in her coccyx approximately the circumference of a dime with yellow slough in the center of the hole. There was no dressing over the pressure ulcer on her buttock or coccyx. LPN 7 cleansed the pressure ulcer wounds with gauze moistened with sterile water. She removed her gloves and left Resident D's bedroom. She returned with some q-tips and donned a clean pair of gloves without washing her hands. She moistened gauze with sterile water and placed over the buttock wound and in the coccyx wound. After placing the moistened gauze on the wounds she placed a 4 x 4 island dressing over both wounds. LPN 7 explained Resident D had an order for santyl, but it had not came in yet so staff had been doing a wet to moist dressing. LPN 7 explained Resident D had not had a dressing on her pressure ulcers when she went in to change her dressing and that she had not washed her hands after returning to Resident D's room with the q-tips and prior to donning clean gloves and proving wound care. The "Hand Hygiene" procedure provided		these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	by the Director of Nursing Services Specialist on 2/24/17 at 4:03 p.m., included the following: "...Five moments for Hand Hygiene: Before touching a patient. Before Clean/Aseptic procedure...." This federal tag relates to Complaint IN00219738 3.1-40(a)(2)			
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives			

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	one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview and record review, the facility failed to evaluate a decline in bladder status and the need for an individualized restorative toileting program for the decline, for 1 of 3 residents reviewed for urinary incontinence. (Resident 34) Findings include: Resident 34's record was reviewed on 2/22/17 at 9:13 a.m. Her significant change Minimum Data Set (MDS) assessment dated 928/16, specified she was occasionally incontinent of urine. Her quarterly MDS assessment dated 12/27/16, specified she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills.	F 0315	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **A 3 day B/B was initiated for resident 34. IDT completed continence review on March 10, 2017** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **All residents who experience a decline in bladder status have the potential to be affected by this alleged deficient practice. MDS/ designee will complete an audit of all resident's most recent MDS assessment by 3/26/17 to determine if a change in bladder**	03/26/2017

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	She required extensive assistance of 1 person for toileting. She was frequently incontinent of urine and was not on a toileting program Resident 34's diagnoses documented on her February 2017 physician's recapitulation orders included but were not limited to, dementia with agitation and mildly mentally retarded. On 2/22/17 at 11:31 a.m., LPN 3 explained Resident 34 ambulated independently and took herself to the toilet. On 2/22/17 at 11:31 a.m., Resident 34 was observed ambulating from the activity room to a bench in the hallway with the assistance of a rollator. She explained she took herself to the toilet. She had the sensation when she needed to urinate but sometimes the urine rushed out before she could do anything. During an interview with the Director of Nursing Services (DNS) on 2/23/17 at 3:15 p.m., she explained a traveling MDS Coordinator had completed Resident 34's quarterly MDS dated 12/27/16. If the DNS had noticed a change in bladder status for Resident 34 she would have ordered a 3 day voiding pattern to determine if there was a pattern		**status occurred. Toileting programs will be initiated as indicated** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **Full time MDS Coordinator has been hired. Bladder status will be assessed for all residents per MDS schedule and as needed. DNS will be notified when a change in Bladder status for a resident occurs. An IDT Continence review will be completed at this time, with Toileting Programs initiated as indicated.** **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Bladder Program QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	to Resident 34's incontinence. If there had been a pattern to Resident 34's incontinence she would have developed an individualized toileting program to assist with the incontinence. The "Bladder Program" procedure provided by the DNS on 2/24/17 at 11:43 a.m., included the following: "Procedure: 1. Each resident will have a d-day voiding pattern initiated within 72 hours of admission and/or any change in continence status. 2. A new 3-day voiding pattern will only be completed if there is a change in level of continence including when a catheter is removed. ...7. After completion of the 3 day pattern the MDS Coordinator/Unit Manager will complete the bladder assessment evaluation and determine if the resident is a candidate for one of the following: Check and change (routine incontinent care). Scheduled toileting program. Formal bladder re-training program...." 3.1-41(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -			

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	(1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.			
	Based on observation, interview and record review, the facility failed to have skid strips on a residents bathroom floor to assist in preventing falls, and failed to have an assist bar positioned on the bed in a manner to prevent accidents, for 2 of 3 residents reviewed for accidents. (Resident E and I) Findings include:	F 0323	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident E's non skid strips were replaced as indicated. Resident I's assist bar was removed from the bed as indicated. **How other residents having the potential to be affected by the**	03/26/2017

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	1. Resident E's record was reviewed on 2/22/17 at 10:22 a.m. Her annual Minimum Data Set (MDS)assessment dated 10/27/16, included she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required supervision of 1 person to walk in her room. She required extensive assistance of 1 person for toileting. She had 1 fall with injury and 1 fall without injury since her last assessment. Resident E's diagnoses documented on her February 2017 physician's recapitulation orders included but were not limited to, history of a stroke, hypertension, diabetes mellitus, neuropathy, history of urinary tract infections, and history of falls. A "Fall Event" for Resident E on 12/3/16 at 5:30 a.m., specified she had an unwitnessed fall. She was found laying on her buttock, resting on her left arm, legs in front of her, and her walker beside the toilet. She had been going to the bathroom with her walker and was turning to toilet and lost her balance. The intervention put into place to prevent another fall was to have non-skid socks on at all times. A "Fall Event" for Resident E on 1/21/17 at 9:15 p.m.,		**same deficient practice will be identified and what corrective actions will be taken?** All residents with fall interventions placed have the potential to be affected by this alleged deficient practice. The facility is to ensure all residents have appropriate preventative measures/ assistive devices when indicated to prevent falls. All resident's profiles were printed and fall interventions were audited to ensure they were in place on 3/13/17. No other residents affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** IDT will review all falls on the following business day and initiate appropriate interventions as indicated. When a fall intervention is initiated it will be placed on the daily CQI minute form to ensure it is followed through on. Resident care plans and profiles will be updated with interventions. Profiles will be available to nursing staff to ensure direct care staff are aware of resident's interventions. Customer care representatives will use resident profiles during room rounds Monday – Friday to ensure all interventions continue to be in place and functioning appropriately. Residents plan of care will be	

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	specified she had an unwitnessed fall. She had been ambulating to the bathroom with her quad cane. She was found lying on her left side in her bathroom floor in front of the toilet. The bathroom floor was wet around the toilet. The intervention put into place to prevent another fall was Resident E was asked to use her call light at night with toileting and staff assistance with bedtime care/transfers with her wheelchair an not her quad cane due to unsteady gait. A "Fall Event" for Resident E on 2/4/17 at 4:01 a.m., specified she had an unwitnessed fall trying to go to the bathroom and was found sitting on her buttocks with her back against the wall in the bathroom. The intervention put into place to prevent another fall was to make sure Resident E used her call cord to alert staff of the need for bathroom assistance. An interdisciplinary team (IDT) progress note for Resident E dated 2/6/17 at 10:12 a.m., explained her fall had been reviewed. Resident E had stated her hip had gave out as she was transferring to the toilet. The IDT determined skid strips would be placed on the floor next to Resident E's left side of her bed and in front of her toilet. A plan of care for Resident E specified she was at risk for falls due to a history of		reviewed at least quarterly and fall interventions will be reviewed for appropriateness at this time. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Fall Management QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.	

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	fall, weakness, and impaired mobility. Her goal included her risk factors would be reduced in an attempt to avoid significant fall related injury. An approach to assist in preventing falls added to her plan of care on 2/7/17, was to have non-skid strips on the floor in front of her toilet. On 2/22/17 at 10:00 a.m., Resident E's bathroom was observed. No skid strips were observed on the floor in front of her toilet. On 2/22/17 at 10:46 a.m., LPN 3 explained Resident E had skid strips on the floor in her bathroom in front of the toilet but they had come off due to urine on the floor. LPN 3 needed to inform the Maintenance staff Resident E needed new skid strips on the floor in front of the toilet. 2. On 2/20/17 at 11:05 a.m., Resident I was observed lying on his bed and had an assist bar (a narrow bar attached to the side of a bed, near the head of the bed, so a resident can hold on to it while rising) on the open side of his bed. The assist bar was near where the resident's knee is when he is laying down. He swung his legs up over the assist bar and sat up on the side of the bed. He said he could lay down, then demonstrated he could lay down by swinging his legs up and over			

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	the assist bar. The other side of his bed was against the wall. On 2/22/17 at 9:50 a.m., Resident I's bed was observed to have the assist bar 2/3 down the bed towards the foot of the bed. Resident I's record was reviewed on 2/22/17 at 9:54 a.m. Current physician's orders revealed diagnoses that included, but were not limited to, depression, anemia, Alzheimer's dementia with behavioral disturbances, and high blood pressure. Diagnoses from a local hospital History and Physical indicated diagnoses of blindness in left eye, benign prostatic hypertrophy, and hypercholesterolemia. Physician's orders indicated an order that he may be up ad lib (by himself when he wants). On 2/24/17 at 10:15 a.m., the assist bar was still in place towards the foot of his bed. On 2/24/17 at 11:38 a.m., the assist bar was observed with the Unit Manager. The resident was lying in bed, then sat up, bent his knees and swung his feet around the bar so he could sit up on the side of the bed. He said he didn't use the bar, and the Unit Manager said it looked like his bed was the wrong way, that the assist bar should have been towards the			

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	head of the bed The resident said he slept this way and pointed to head of the bed, where his pillow was, at the other end from the assist bar. On 2/24/17 at 12:08 p.m., the Director of Health Services Specialist provided a quality assurance tool for side rails as their policy and said they assess for the use of side rails but not the assist bars. An admission fall risk assessment, dated 2/3/17, indicated Resident I had had no falls within the previous 6 months, and had a total fall risk score of 4 points to indicate a low fall risk. A care plan, dated 2/9/17, indicated a problem for: "Resident is at risk for fall due to: age >65, dementia, impaired tissue perfusion, vision impairment. Goal: Resident fall risk factors will be reduced in an attempt to avoid significant fall related injury. Approaches: Call light in reach. Environmental changes: new environment for resident, been inpatient psychiatric floor. Non skid footwear. Personal items in reach. Therapy screen." The "Fall Management Program" provided by the Director of Nursing Services on 2/24/17 at 11:43 a.m., included the following: "Post fall: ...4.			

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	A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. An entry will be completed in the EMR addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future falls. The fall event will be reviewed by the team. A CQI form will be completed for necessary follow-up. The care plan will be reviewed and updated, as necessary." 3.1-19(c) 3.1-45(a)(1) 3.1-45(a)(2)			
F 0463 SS=D Bldg. 00	483.90(f)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (f) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance			

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	155230	A. BUILDING 00 B. WING	02/24/2017

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	through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident had a call light available for 1 of 35 residents observed for call lights. (Resident 25) Findings include: Resident 25's record was reviewed on 2/24/17 at 12:40 p.m. Her quarterly Minimum Data Set (MS) assessment dated 10/8/16, included she was she was understood and had the ability to understand others. She was severely impaired in her cognitive daily decision making skills. She required extensive assist of 1 person for bed mobility, to walk in her room, toileting, and personal hygiene. She required extensive assistance of 1 person for transfer. Resident 25's diagnoses documented on her 2017 physician's recapitulation orders included but were not limited to, vascular dementia with behavioral disability, insomnia, and glaucoma. On 2/21/17 at 9:09 a.m., Resident 25 was observed lying in bed. She had an alarm box cord plugged in to her call light box on the wall. She had no call light cord	F 0463	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 25 was provided with all call light, placed within reach **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by this alleged deficient practice. IDT visited every resident room on February 27, 2017 to ensure a call light was available to resident and within reach. No other residents were found to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be inserviced by March 26, 2017 on the importance of making sure that call lights are available for all residents and to notify the ED/ DNS immediately if call light is observed to be missing, and to ensure call light is always within residents reach. Customer	03/26/2017

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	available. At that time LPN 3 clarified Resident 25 had not had a call light cord available. On 2/21/17 at 9:10 a.m., Maintenance explained an alarm box cord had been plugged into the call light box but no a call light cord was available. He would get a new call light cord and put it in Resident 25's room. On 2/24/17 at 1:14 p.m., the Director of Nursing Services (DNS) voiced Resident 25 had used her call light in the past and would push her call light button if asked to. 3.1-3(v)(1)		care reps will complete resident room rounds Monday through Friday, during which they will make sure call lights are available for all residents. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the DNS/ designee is responsible for the completion of the Environment QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance and disciplinary action taken as needed.	
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;			

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	(iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure an inventory sheet was signed by the resident or resident's representative upon admission or discharge. This affected 1 of 3 residents reviewed for closed records. (Resident H) Findings include: Resident H's closed record was reviewed on 2/24/17 at 2:25 p.m. Admission diagnoses, dated 11/17/16, revealed diagnoses that included, but were not	F 0514	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident H discharged from facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **All residents have the potential to be affected by this alleged deficient practice. SS will conduct an audit on**	03/26/2017

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	limited to, spinal narrowing of the neck region, pressure ulcer, chronic pain, depression, urinary tract infection secondary to chronic indwelling Foley catheter, anemia, heart disease, high blood pressure, congestive heart failure, type 2 diabetes, chronic kidney disease stage 3, and paraplegia (paralysis of the lower trunk and legs). Progress notes, dated 1/9/17 at 7:20 p.m., revealed: "res (resident) left facility with [Name of ambulance service] d/c (discharged) to home with home care to [Family member's name]'s house; res and [Family member] both informed of appt (appointment) needed for pcp (primary care physician). 3 day supply of meds sent home with res...." The "Inventory of Personal Belongings" sheet failed to have signatures and dates upon admission and the resident or responsible party signature and date upon discharge. On 2/24/17 at 3:55 p.m., the Director of Health Services indicated Resident H went home on January 9th and the family nor the resident did not sign the inventory of personal belongings when he was discharged. She said they are supposed to sign and indicated the line on the Inventory of Personal Belongings sheet		**all residents by 3/26/17 to ensure inventory sheets are present and signed in resident charts. Any resident identified as affected by this practice with have inventory completed, with inventory sheet signed by the appropriate people** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education to be provided to nursing staff on importance of having inventory sheet filled out and signed by staff and resident on admission and at discharge to ensure all items are accounted for by 3/26/17. IDT will audit all new admission, readmissions and discharges for proper signatures of inventory sheet on the following business day. If resident or family refuses this will be documented. **How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** To ensure compliance, the SSD/ designee will complete an audit of all new admissions and discharges to ensure inventory sheets are present and complete weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two	

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	above the line where 2 staff members had signed. The section for admission did not have any signatures for the resident, responsible party, staff or dates. 3.1-50(a)(1)		consecutive quarters. The results of these audits will be reviewed during monthly QAPI meeting overseen by the ED.	