

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Surveyor Dates: March 26, 27, 28, 29, 30 & April 2, 2012.</p> <p>Facility Number: 000353 Provider Number: 155651 AIM Number: 100291330</p> <p>Survey Team: Patti Allen, BSW, TC Marcy Smith, RN Leia Alley, RN Dinah Jones, RN</p> <p>Census Bed Type: SNF/NF: 102 SNF: 3 Total: 105</p> <p>Census Payor Type: Medicare: 14 Medicaid: 72 Other: 19 Total: 105</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 10, 2012 by Bev Faulkner, R.N.</p>	F0000	<p>This plan of correction is submitted in compliance and conformance with State and Federal requirements. This plan of correction is not an admission to nor does it signify agreement with the survey allegations, rather it is submitted because it is required. This survey report does not present an accurate depiction of the manner in which nursing care and services are provided to this facility's residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to provide documentation indicating two days notice was provided regarding Medicare coverage for 1 of 1 resident (Resident #115) reviewed for notification of Medicare non-coverage.</p> <p>Findings include:</p> <p>On 3/30/12 at 3:00 P.M., one Notice of Medicare Non-Coverage was received and reviewed.</p> <p>A "Notice of Medicare Provider Non-Coverage" form for Resident #115 indicated "The effective date coverage of current rehabilitation services will end March 1, 2012."</p>	F0156	<p>1. Unable to correct Notice of Non-coverage for resident #115.2. All residents have the potential to be affected3. Interdisciplinary team was in-serviced on the necessity of the Notice of Medicare non coverage form being given timely.4. Business Office Manager/designee will review all Notice of non-coverage letters times one month then review 5 letters per month for timely notice. Findings will be presented to the Quality Assurance Coimmitttee for any action. The QA committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>	05/02/2012

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	<p>The form indicated Resident #115's Power of Attorney (POA) signed and dated the form on 2/29/12, indicating he had received the notice on that date, one day prior to the ending of the Medicare coverage.</p> <p>3.1-4(f)(3)</p>				

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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure activities were provided to meet the needs of 2 of 3 residents reviewed for activities in sample of 10 who met the criteria for activities review. (Residents #126 and #8)</p> <p>Findings include:</p> <p>1. The record of Resident #8 was reviewed on 3/29/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #8 included, but were not limited to, stroke, Parkinson's disease, aphasia and senile dementia.</p> <p>A review of Resident #8's annual Minimum Data Set (MDS), dated 1/3/12, indicated it was very important for her to keep up with the news and go outside but not important to do things with groups of people.</p> <p>A care plan for Resident #8, dated 1/3/12, indicated "Focus tends to</p>	F0248	<p>1. Resident #8 one to one activity was increased to 45 minutes per week three times a week per her interest. Resident #126 was interviewed for the type of evening activity program she wanted to have. We will offer a Sunday evening staff directed activity of the resident's interest and have the approval/ideas of the Resident Council Committe.</p> <p>2. All residents on a one-to-one program have the potential to be affected. All resident on a one-to-one program time have been increased to at least 30 minutes per week. All residents have the potential to be affected.3. A resident council meeting will be held to determine if the residents desire additional evening programs. Programs will be added as indicated.4. Activity Director/designee will audit one to one programs weekly times 2, then monthly times 2 and report the finding to Quality Assurance Committee for needed action. Evening programs will be audited to ensure that information received from the resident council meeting has been addressed. The QA</p>	05/02/2012			

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	<p>stay in room per choice able to make decisions regarding activity pursuits...Goals she will engage in informal act. of interests daily read bible, watch tv, outdoors peering, listen to music to benefit sense of well-being by next review. She will accept 1:1 room visits wkly for extra stimulation-socialization by next review. She will accept hand massages and gaming during visits to benefit sense of well-being each visit. Interventions 1. assist with providing informal act. materials 2. provide 1:1 room visits...and provide stimulating activities during visits...</p> <p>During an interview with the Activity Assistant on 3/30/12 at 8:35 a.m., she indicated she visited Resident #8 either 2 times per week for 10 minutes each, or 1 time per week for 20 minutes. She indicated she usually read stories to her. She indicated "I usually go once a week for 20 minutes because she [Resident #8] loves her time with me and doesn't want me to go after 10 minutes."</p> <p>During an interview with Resident #8 on 3/30/12 at 9:20 a.m., she indicated she really liked it when the activity person came and read to her and would love to have it more than just</p>		committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.		

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	<p>20 minutes per week.</p> <p>Review of an undated facility policy titled "One to One Programming," received from the Medical Records staff on 4/2/12 at 4:04 p.m., indicated "Purpose: One-to-one programming is necessary for any resident who does not participate in traditional activity program or does not pursue life in the facility. One-to-one programming shall total 30 minutes per week...."</p> <p>2. The record of Resident #126 was reviewed on 3/29/12 at 10:30 a.m.</p> <p>Diagnoses for Resident #126 included, but were not limited to, chronic airway obstruction, stroke, diabetes, anxiety and depression.</p> <p>A care plan for Resident #126, dated 2/27/12, indicated a Focus of "...able to initiate informal activity pursuits - I enjoy group activities and being social...states she does not want to be reminded of group activities, she has a calendar and will initiate coming to the activities she is interested in."</p> <p>During an interview with Resident #126 on 1/27/12 at 11:00 a.m., she indicated there were hardly any activities offered in the facility after</p>				

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	<p>dinner in the evening. She indicated she would be interested in having more things to do socially after dinner.</p> <p>Review of the Activity Schedules, received from the Activity Director on 3/30/12 at 9:15 a.m. indicated the following: March, 2012: Bingo scheduled on 3/1, 3/7, 3/14, 3/15, 3/21/ 3/28 and 3/29, 2012 Church service: 3/26, 2012 Movie: 3/4 and 3/18, 2012 Church band: 3/22, 2012 Summary of March evening activities: 7 bingo nights, 2 movie nights, 1 church night and 1 church band night. There were no activities scheduled on 2 of 4 Sunday evenings, 3 of 4 Monday evenings, 4 of 4 Tuesday evenings, 5 of 5 Friday evenings and 5 of 5 Saturday evenings.</p> <p>April, 2012: Bingo scheduled on 4/4, 4/5, 4/11, 4/18, 4/19, 4/25, 2012 Church music: 4/26 and 4/30, 2012 Summary of April evening activities: 6 bingo nights, 2 church music nights There were no activities scheduled on 5 of 5 Sunday evenings, 4 of 5 Monday evenings, 4 of 4 Tuesday evenings 4 of 4 Friday evenings and 4 of 4 Saturday evenings.</p>			

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	3.1-33(a)			

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to comprehensively assess a resident with a limit in range of motion to ensure care was provided to prevent further decrease in range of motion. This affected 1 of 2 residents</p>	F0272	1. MDS of resident #153 was corrected.2. All residents with contracture have the potential to be affected. The last MDS of residents with contractures was reviewed and corrected if indicated.3. In-serviced MDS Coordinators on assessment and coding of Funcional Limitation in	05/02/2012	

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	<p>reviewed for range of motion limitations. Resident #153.</p> <p>Findings Include:</p> <p>The record for Resident #153 was reviewed on 3/30/2012 at 9:00 a.m.</p> <p>Diagnoses included but were not limited to, muscle weakness, traumatic fracture to lower leg and rheumatoid arthritis.</p> <p>An Admission MDS (Minimum Data Set) record, completed on 1/19/2012, indicated that Resident #153 had no functional limitation in range of motion.</p> <p>Her MDS assessment, dated 3/10/12, indicated she had impaired range of motion in both her upper extremities.</p> <p>During an interview on 3/27/12 at 11:00 A.M., with Employee #7, LPN (Licensed Practical Nurse), she indicated that Resident #153 had crippling arthritis and had contractures to both her hands.</p> <p>During an interview with Resident #153's COTA (Certified Occupational Therapy Assistant) on 3/30/12 at 3:35 p.m., she indicated Resident #153 does not have contractures and that</p>		<p>Range of Motion section of the MDS.4. DON/designee will review 5 completed MDS weekly times 4, then monthly times 3 for accurate coding of Range of Motion. Findings will be reported to the Quality Assurance Committee for any action. The QA committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>		

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	<p>she uses her hands for her personal computer and types texts messages on her cell phone. The COTA also indicated Resident #153 is able to open her hands and is able to properly function. The COTA indicated that the Therapy department did not have a care plan for Resident #153's hands, only for the fracture to her leg and no modalities for hands in therapy because the resident was able to function and that Resident #153 is not doing any weight bearing exercises with her hands.</p> <p>During an observation and interview with Resident #153, right after the therapy interview with the COTA, Resident #153 showed and explained that she was unable to open her left hand at all and has limited movement of her right hand. She was able to turn the TV off with a remote with the right hand. She explained that was a difficult task for her to do. A laptop computer and cellular telephone was observed on the bedside table of Resident #153. Resident #153 indicated therapy isn't doing anything in regards to keeping her hands from contracting but is helping her learn to stand and walk again.</p> <p>During an interview with the MDS</p>				

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	<p>Nurse at 3:00 p.m., on 4/2/12 she indicated the 60 day MDS assessment was in error, that she did not feel that Resident #153 has a limitation in range of motion that interfered with her daily functions or that resident was at risk of injury related to the arthritis in her hands. She indicated Resident #153 was able to function day to day.</p> <p>3.1-31(a)</p>			
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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received ongoing monitoring of his dialysis access site for 1 of 1 residents reviewed for dialysis care. (Resident #147)</p> <p>Findings include:</p> <p>The record of Resident #147 was reviewed on 3/29/12 at 1:30 p.m.</p> <p>Diagnoses for Resident #147 included, but were not limited to, end stage renal disease and history of acute respiratory failure.</p> <p>Resident #147's record indicated he had an intravenous central line which was used for his dialysis access site every Monday, Wednesday and Friday.</p> <p>A care plan for Resident #147, dated 2/8/12, indicated a "Focus" of "I have</p>	F0309	<p>1. Orders were obtained on resident #147 for nurses to assess the access site every shift. 2. Ther were no other residents affected.3. An in-service will be provided to the nursing staff on the care of the dialysis fistula and port. All dialysis residents will have an order to assess access sites every shift and documentation of the assessment will be placed in the electronic medical record.4. The DON/designee will complete an audit on all dialysis residents 5 days/wk X2 weeks, then monthly X2. Results of the audit will be sent to the Quality Assurance Committee for review to address any further need for monitoring. The QA committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>	05/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012
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	<p>a central line present to my right chest related to the need for dialysis." A goal was "No signs or symptoms of infection will be noted daily thru the next review."</p> <p>A care plan for Resident #147, dated 2/8/12, indicated a problem of "Dialysis" related to renal failure. Interventions included "Monitor/document/report to MD prn (as needed) any s/sx (signs or symptoms) of infection to the access site..."</p> <p>Review of the resident's record did not indicate his central line access site was being monitored daily.</p> <p>During an interview with RN #3 on 3/30/12 at 1:00 p.m., she indicated Resident #147 had a dressing covering his central line site and "We don't do anything with it. Dialysis does all the care. All we have to do is check the dressing." She indicated she was not able to find any assessments of the dialysis catheter.</p> <p>During in interview with Regional Nurse Consultant #6 on 3/30/12 at 1:30 p.m., she indicated the nurses should check the dressing every shift. She indicated she could only find "sporadic assessments." She</p>				

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	indicated at this time she had made a "new form" to be used by the nurses for residents receiving dialysis. 3.1-37(a)				

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion to her hands received services to prevent further decrease in range of motion. This affected 1 of 2 residents reviewed for range of motion limitations, in a sample of 2 residents who met the criteria of Range of Motion. Resident #153.</p> <p>Findings Include:</p> <p>The record for Resident #153 was reviewed on 3/30/2012 at 9:00 a.m.</p> <p>Diagnoses included but were not limited to, muscle weakness, traumatic fracture to lower leg and rheumatoid arthritis.</p> <p>An Admission MDS (Minimum Data Set) assessment, completed on 1/19/2012, indicated that Resident #153 had no functional limitation in range of motion. Her MDS assessment, dated 3/10/12,</p>	F0318	<p>1. Resident #153 was on Occupational Therapy caseload at the time of interview. Occupational Thyerapy will re-evaluate the resident's ability to use her hands.2. All residents with limited range of motion have the potential to be affected. All residents with limited range of motion are being screened by therapy to evaluate if additional treatment or services are needed to prevent further decrease in range of motion.3. In-service nursing staff to report a decline in ADL functions to therapy in order to screen for a potential decline in range of motion.4. DON/designee will audit residents with limited Range of Motion that are receiving services/treatment to prevent/decrease further Range of Motion, weekly x2, then monthly x3. Any findings would be reported to the Quality Assurance Committee for action. The QA committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>	05/02/2012			

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NAME OF PROVIDER OR SUPPLIER HOMEVIEW CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131
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	<p>indicated she had impaired range of motion in both her upper extremities.</p> <p>During an interview on 3/27/12 at 11:00 A.M., with LPN Employee #7, she indicated that Resident #153 had crippling arthritis and had contractures to both her hands.</p> <p>During an interview with Resident #153's COTA (Certified Occupational Therapy Assistant) on 3/30/12 at 3:35 p.m., she indicated Resident #153 does not have contractures and that she uses her hands for her personal computer and types texts messages on her cell phone. The COTA also indicated Resident #153 is able to open her hands and is able to properly function. The COTA indicated that the Therapy department did not have a care plan for Resident #153's hands, only for the fracture to her leg and no modalities for hands in therapy because the resident was able to function and that Resident #153 is not doing any weight bearing exercises with her hands.</p> <p>During an observation and interview with Resident #153, right after the therapy interview with the COTA, Resident #153 showed and explained that she was unable to open her left</p>			

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	<p>hand at all and has limited movement of her right hand. She was able to turn the TV off with a remote with the right hand. She explained that was a difficult task for her to do. Resident #153 indicated therapy was not doing anything in regards to keeping her hands from contracting, but is helping her learn to stand and walk again.</p> <p>During an interview with the MDS Nurse at 3:00 p.m., on 4/2/12, she indicated that the 60 day MDS assessment was in error, that she did not feel that Resident #153 has a limitation in range of motion that interfered with her daily functions or that resident was at risk of injury related to the arthritis in her hands. She indicated Resident #153 was able to function day to day.</p> <p>3.1-42(a)(2)</p>				

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure nutritional status was maintained for 1 of 3 residents reviewed for nutritional status in a sample of 9 who met the criteria for being nutritionally at risk. (Resident #94)</p> <p>Findings include:</p> <p>The record of Resident #94 was reviewed on 3/28/12 at 10:00 a.m.</p> <p>Diagnoses for Resident #94 included, but were not limited to, end stage renal failure, gait abnormality, chronic airway obstruction, pneumonia, stroke diabetes, depression and anxiety.</p> <p>A care plan for Resident #94, dated 2/27/12, indicated "Focus Nutritional problem or potential nutritional problem related to on dialysis Goals Weight will remain stable..."</p>	F0325	<p>1. No corrective action has been put in place for the resident affected by this practice as resident #94 no longer resides in the facility.2. All admissions within the past 30 days have been reviewed to ensure that admission weights were obtained timely and weekly weights are being obtained for 4 weeks following admission. 3. An in-service will be completed with nursing staff on the facility Weight Policy. New admit charts will be audited per DON/designee to ensure admission weights are obtained on the day of admission and weekly weights for the first four weeks.4. An audit of all new admit charts will be completed per the DON/designee weekly x4 weeks, then monthly x3. Results of the audit will be sent to Quality Assurance Committee for review and to address further need for monitoring. The QA committee will monitor monthly in QA meeting. The QA will continue monthly until substantial</p>	05/02/2012			

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	<p>Resident #94 was admitted to the facility on 2/24/12.</p> <p>Review of Resident #94's documented weights indicated her admission weight, which was not taken until 2/29/12, was 133 pounds (lbs). The next weight was recorded on 3/10/12 as 124 lbs, followed on 3/17/12 with 125 lbs.</p> <p>She was admitted to the hospital on 3/17/12 and did not return to the facility.</p> <p>In an interview with the Assistant Director of Nursing on 3/29/12 at 10:15 a.m., she indicated new admissions should be weighed upon admission and weekly for 3 more weeks.</p> <p>A facility policy titled "Weights," dated 3/2012, received from Regional Consultant #6 on 4/2/12 at 4:08 p.m., indicated "Purpose...2. To provide an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident...Procedure: 1. Residents will be weighed upon admission and weekly for 4 weeks after admission....3. Residents with a significant weight change in one week</p>		compliance is achieved.				

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	(gain/loss of 5 pounds or more) in one week will result in a reweight..." 3.1-46(a)(1)				

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NAME OF PROVIDER OR SUPPLIER HOMEVIEW CENTER OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131			
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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure drugs were labeled for date</p>	F0431	1. Medication labels were marked with date of opening per the pharmacy delivery date on residents #128, #45, #23, #100, #27, #22, #136, #36, #95, and	05/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012	
NAME OF PROVIDER OR SUPPLIER HOMEVIEW CENTER OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131			
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	<p>opened/expiration date on 3 of 5 medication carts and insulin was disposed of when expired on 1 of 5 medication carts. This had the potential to affect 11 of 11 residents. (Residents #128, 45, 36, 23, 100, 27, 147, 95, 22, 136 and 56)</p> <p>Findings include:</p> <p>During an observation of Station 1 back hall medication cart on 4/2/12 at 10:15 a.m., with LPN #1, the following was observed:</p> <p>Naphcon-A eye drops for Resident #23 was not marked with an open date.</p> <p>Dorzolamide-timolol eye drops for Resident #128 was not marked with an open date.</p> <p>Latanoprost 0.005% eye drops for Resident #128 was not marked with an open date.</p> <p>Combigan eye drops for Resident #45 was not marked with an open date.</p> <p>A Novolog Flex Pen Syringe for Resident #56 was not marked with an open date.</p> <p>A Novolog Flex Pen Syringe for Resident #36 was not marked with an open date.</p> <p>During an interview at this time with LPN #1, she indicated "We're supposed to make sure we mark the</p>		<p>#56. The expired medication for resident #147 was disposed of, newly obtained and date opened was applied.2. All residents receiving insulin or eye drops have the potential to be affected. An audit was completed by the Unit Managers of all the medication carts to ensure all dates opened were present and no medications were expired.3. An in-service will be presented to nursing staff on the Expiration Dates and Compromised Medication Policy. Nurse duties were added to the cleaning schedule to include checking the medication carts for documentation on the date opened and expired medication 2x week.4. DON/designee will complete an audit of medication carts checking for documentation of date opened and expired medications 2x week x4 weeks, then monthly x2. Results of the audit will be sent to the Quality Assurance Committee for review to address any further need for monitoring. The QA Committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>				

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	<p>open date on insulin and eye drops and not give medication that is expired."</p> <p>During an observation of Station 1 front hall medication cart on 4/2/12 at 10:25 a.m., with Qualified Medication Aide (QMA) #2, the following was observed:</p> <p>Refresh eye drops for Resident #100 was not marked with an open date. Dorzolamide-Timolol eye drops for Resident #27 was not marked with an open date.</p> <p>During an interview with QMA #2 at this time she indicated "We're supposed to put an open date on insulin and eye drops."</p> <p>During an observation of Station 3 front hall medication cart at 10:42 a.m., with RN #3, the following was observed:</p> <p>Novolog Insulin for Resident #147 was marked opened on 2/23/12. During an interview with RN #3, at this time, she indicated the insulin for Resident #147 was expired because it had been longer than 28 days since the bottle was opened.</p> <p>During an observation of Station 2 medication cart with Licensed</p>						

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NAME OF PROVIDER OR SUPPLIER HOMEVIEW CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131
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	<p>Practical Nurse #4 (LPN) at 11:00 a.m.,the following was observed:</p> <p>Levimir Insulin for Resident #95 was not marked with an open date. Novolog Insulin for Resident #95 was not marked with an open date. Lotemax 0.5% eye drops for Resident #22 was not marked with an open date. Ofloxacin 0.3% for Resident #136 was not marked with an open date. Genteal Severe Dry Eye eye drops for Resident #22 was not marked with an open date.</p> <p>During an interview with LPN #4, at this time, she indicated "We should put an open date on all the insulin and eye drops.</p> <p>Review of a facility policy, received from Regional Consultant Nurse #5 on 4/2/12 at 1:50 p.m., titled "Expiration Dates and Compromised Medication," indicated "Policy: Expiration dates assure the adequate potency and effectiveness of medications...3. With some multi-dose containers it is important to complete the 'Date Opened' sticker. The expiration date is then dependent on this date.</p> <p>3.1-25(j)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, record</p>	F0441	Glucometer Cleaning1. All glucometers will be cleaned with	05/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012
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	<p>review, and interview, the facility failed to establish an appropriate glucometer cleaning program to prevent the spread of infectious pathogens to residents receiving blood sugar monitoring. This had the potential to effect 40 of 105 residents who receive regular blood sugar monitoring.</p> <p>B. Based on observation. record review and interview, the facility failed to ensure appropriate hand washing techniques were used in 1 of 5 random observations of resident care. (Resident # 128, CNA # 9))</p> <p>Findings include:</p> <p>A.1. During an observation on 3/29/12 at 9:50 a.m., and in the presence of LPN (Licensed Practical Nurse) #1, LPN #1 was observed cleaning the glucometer after use with a Sani-Cloth Plus wipe.</p> <p>During an interview at the time of observation with LPN #1, she indicated she thought that the cloth wipe was alcohol based and didn't</p>		<p>a cleansing cloth which kills C-Diff spores following each use.2. All diabetics receiving accu-checks have the potential to be affected. Two glucometers will be kept in each medication cart to ensure appropriate disinfectant time is being completed between uses. Bleach cloths were added to our facility formulary. The bleach cloths are used in accordance to manufacturer's recommendation of 5 minutes.3. An in-service will be completed with nursing staff on our new Glucometer Cleansing Policy. Return demonstration skill shek offs were completed with our nursing staff. 4. An audit of medication carts will be completed per the DON/designee weekly X4 to ensure that correct wipes are being used to disinfect the glucometers, then monthly X2. Results of the audit will be sent to the Quality Assurance Committee for review to address any further need for monitoring. The QA Committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.Hand Washing1. Staff members will wash their hands for 20 seconds.2. All residents residing on Station 1 have the potential to be affected. 1:1 in-service was completed with the staff member who demonstrated the practice.3. An in-service was held with all nursing staff on 4/10/12 regarding our new Hand</p>		

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	<p>contain any bleach. LPN #1 indicated this is how she normally cleaned her machine and she has 10 out of 18 residents that she is responsible for,who receive blood sugar testing with a glucometer machine.</p> <p>During an interview on 3/29/12 at 10:15 a.m., with the Regional Nurse Consultant (RNC) # 5, she stated "We are getting ready to switch to the ones that will kill C-diff (Clostridium difficile; an intestinal bacteria that causes severe diarrhea) " and indicated she was unaware of any cleaning clothes that were approved to kill the bacteria. Employee #5, RNC also indicated there were no residents in the building who received blood sugar monitoring and was positive for C-diff.</p> <p>During a review of the glucometer manufacturer's instructional booklet on 3/29/12 at 10:30 a.m., it indicated the best way to disinfect the machine was with a 1:10 bleach solution.</p> <p>During an observation of an blood</p>		<p>Washing Policy. Return demonstration skill check-offs are being completed on nursing staff.4. DON/designee will complete audits of staff members washing their hands 5 days/week on different shifts X2, then weekly X4, then monthly X2. Results of the audit will be sent to the Quality Assurance Committee for review to address any further need for monitoring. The QA Committee will monitor monthly in QA meeting. The QA will continue monthly until substantial compliance is achieved.</p>		

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	<p>sugar testing with a glucometer on 3/29/12 at 11:20 a.m., and in the presence of Qualified Medication Aide (QMA) -Employee #2, the QMA was observed to use the glucometer to test a resident, then cleaned the machine with the "Sani Cloth Plus" wipe, and was stopped just before testing another resident.</p> <p>On 3/29/12, interviews were conducted with all the staff nurses responsible for blood sugar monitoring with a glucometer machine. All the nurses indicated they all used the "Sani Cloth Plus" wipe to clean their glucometer machines.</p> <p>During an interview with the Sales Representative for the facility's glucometer machines on 3/29/12 at 2:25 p.m., he indicated the cloth wipes the facility was using were not effective in killing the C-diff bacteria and that it was new product that his company was not suggesting the use of at the time of the survey.</p>			

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	<p>During an interview with Employee #8, Regional Nurse Consultant, on 3/29/12 at 3:00 p.m., she indicated the facility had totally switched over to disinfectant bleach cloths.</p> <p>B.1 During an observation of Resident #128 on 3/30/12 at 3:05 p.m., Certified Nurse Aide (CNA) # 9 went in Room 117 carrying a portable Oxygen (o2) tank and she applied Resident #128's o2 tubing. She lifted the resident's feet, so she could remove the resident's foot pedals from resident's wheelchair. Next, she put a gait belt around the waist of the resident and pushed the wheelchair into the restroom. Then CNA # 9 washed her hands for less than 10 seconds and then she assisted the resident in locking the wheelchair. Next, CNA # 9 helped pull down the resident's pants and incontinent brief and helped Resident #128 sit on the commode. Then she washed her hands for less than 10 seconds and reminded the resident to turn on the cal light when she was done.</p> <p>Interview with CNA # 9 following the observation, she indicated she would have washed her hands before she started and indicated she should have washed them until she completed</p>				

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	<p>singing the "Ole McDonald" tune or about 15 seconds. CNA # 9 did not use gloves during removal of resident's incontinent briefs.</p> <p>Review of facility policy on 3/30/12 at 4:30 p.m., listed the following: "2. Apply one squirt of soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly. Wash up to your wrist as well. Do this for at least 15 seconds."</p> <p>"When to Wash Hands (at a minimum) Before and after each resident contact After touching a resident or handling his or her belongings."</p> <p>Interview with Regional Nurse Consultant #6 on 3/30/12 at 4:30 p.m., indicated this was the policy the facility was using.</p> <p>3.1-18(b) 3.1-18(l)</p>			

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F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview, the facility failed to ensure the Quality Assurance Committee identified and implemented a plan of action for the identified concerns of infection control, weights to reflect nutritional status, activity programming, monitoring of dialysis access site, labeling of drugs for date opened/expiration, comprehensive assessment of a resident for a limit in range of motion, and timely Notice of</p>	F0520	<p>1. The Quality Assurance Committee reviewed and approved the action plans for activity programs, accuracy of MDS, labeling of medication, monitoring dialysis access site, weights to reflect nutritional status, concerns of infection control, assessment of range of motion, timely Notice of Change related to Medicare coverage, and activities of the Quality Assurance Committee.2. All residents have the potential to be affected. 3. The Quality</p>	05/02/2012

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	<p>Changes related to Medicare coverage.</p> <p>This deficient practice had the potential to affect 40 of 105 residents who received glucose testing using glucometers, 11 residents whose medications failed to have open date labels, 2 residents reviewed for activity programming, 1 resident reviewed for limitations with range of motion and 1 resident receiving dialysis services.</p> <p>Findings include:</p> <p>Interview with the ED (Executive Director)On 4-02-12 at 4:20 p.m., indicated that the Quality Assurance Committee had not addressed weights to reflect nutritional status, Activity Programs for evening activities, one on one activities, or meeting the interest of all residents. He also indicated that the facility's Quality Assurance Committee meets every month and consists of himself, the Director of Nursing, and department heads as well as the Medical Director. It was also indicated that the Quality Assurance Committee had not addressed Monitoring of dialysis access site, Labeling drugs (eye drops, insulin) for date of open/expiration. He indicated that the Quality Assurance Committee</p>		<p>Assurance Committee has been in-serviced on their role.4. The Regional Director of Operations will review the functions of the Quality Assurance Committee 1x month x 2 months and quarterly x 1 quarter for any recommendation to assist committee function.</p>		

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	<p>had failed to address comprehensively assessing the resident for a limit in range of motion, nor had they addressed Notice of changes in Medicare service in a timely manner. He further indicated that the Quality Assurance Committee had last addressed infection control cleaning of glucometer when they did a policy revision in January 2010, but had not revisited since. He indicated he was not sure when the Quality Assurance Committee had last addressed hand washing.</p> <p>3.1-52(b)(2)</p>			