

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 8, 9, 10, 11 and 12, 2012</p> <p>Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850</p> <p>Survey Team: Toni Maley, BSW, TC Tammy Alley, RN Donna M Smith, RN (10/8, 9, 10, 11/12)</p> <p>Census Bed Type: SNF/NF: 51 SNF: 9 Total: 60</p> <p>Census Payor Type: Medicare: 16 Medicaid: 42 Other: 2 Total: 60</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/18/12 Cathy Emswiller RN</p>	F0000		
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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=B	<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 ensure a 2 day notice was given when payment source was changing for 2 of 5 residents reviewed for liability notices. (Resident # 14 and # 26)</p> <p>Findings include:</p> <p>A "SNF [skilled nursing facility] Determination on Continued Stay" was provided on 10/10/12 at 3 p.m., by the Administrator for Resident # 14 and Resident # 26. The forms indicated:</p> <p>Resident # 14 admitted on 12/3/11. The notice was dated 2/14/12 and indicated the resident "...no longer qualified as covered under Medicare beginning 2/15/12."</p>	F0156	<p><u>Corrective Action:</u> Resident #14 and #26 did not have any identified issues/concerns by not receiving the Medicare non covered letter timely. The residents transitioned to long term care with family involvement.</p> <p><u>Identification:</u> An audit of the resident files was conducted by the new Business Office Manager and no other residents were affected by this alleged deficient practice.</p> <p><u>System Changes:</u> A new Business Office Manager was hired in September. Review of the guidelines was completed by the Administrator during general orientation. The Business Office Manager is required to attend the weekly Medicare meeting, in which the interdisciplinary team reviews the dates of coverage. The determination is made for notification of the non covered letter well in advance to ensure</p>	11/11/2012			

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	<p>Resident # 26 was admitted on 4/26/12. The notice was dated 5/22/12 and indicated the resident "...no longer qualified as covered under Medicare beginning 5/23/12."</p> <p>A form titled "SNF Notices of Non-Coverage" was provided on 10/9/12 at 2 p.m., by the Administrator and during an interview at this time she indicated she used this form as guidance when to provide non-coverage letter. The form indicated: "...Beneficiary drops to a non-skilled level of care...when to give notice...no later than 2 days before covered services end...."</p> <p>3.1-4(a)</p>		<p>timely notification. <u>Monitoring:</u> The Administrator will review compliancy on an ongoing base by requiring the Non-Covered notification be duly signed by the Business Office Manager and the Administrator. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified regarding not giving a scheduled insulin for 1 of 4 residents reviewed receiving routine</p>	F0157	<p><u>Corrective Action</u></p> <p>Resident #83 did not have any identified issues/concerns/problems by not receiving the insulin that</p>	11/11/2012

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	<p>insulin medication. (Resident #83)</p> <p>Findings include:</p> <p>On 10/10/12 at 10:30 am., Resident #83's record was reviewed. The resident's diagnoses included, but were not limited to, Diabetic Mellitus. The physician's orders, dated 9/21/12, was Levemir 100 u/ml vial inject 15 units every morning.</p> <p>The "MEDICATION ADMINISTRATION RECORD" for 9/2012 indicated on 10/1/12 at 7:30 a.m., the Levemir dose in the morning had circled initials. In the nurse's medication notes the information indicated the insulin was not given due to a blood sugar of 87 with no further information indicated related to "REASON" and/or "RESULTS/RESPONSE."</p> <p>No information was indicated in the "NURSE'S NOTES" and/or in a "DAILY SKILLED NURSE'S NOTES" related to a physician's notification for the held insulin on 10/1/12 at 7:30 a.m.</p> <p>On 10/11/12 at 2:15 p.m. during an interview, the Director of Nursing indicated the physician should had been notified related to the held</p>		<p>morning as evidenced by skilled nursing notes dated 10-1-12 that resident showed no signs/symptoms of hypoglycemia and/or hyperglycemia.</p> <p>-</p> <p>Identification</p> <p>Residents that receives insulin on a regular basis has the potential to be affected by this alleged deficient practice. Licensed staff will be in-serviced on notification of physician when insulin is withheld on or before 11/9/12.</p> <p>System Change</p> <p>When an insulin dose is held due to low blood sugar the MAR (medication administration record) will reflect the reason the insulin was held along with further follow-up as to the resident's response to the withholding of the insulin in the "results/response" column. Any additional documentation as to physician notification and follow-up will be completed in the nursing notes.</p> <p>Monitoring</p> <p>Residents requiring insulin will have a "Diabetic System Review</p>		

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	insulin on 10/1/12 at 7:30 a.m. 3.1-5(a)		Audit" completed weekly for three months, monthly for three months and quarterly for 3 quarters. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.		

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observations, and interviews, the facility failed to ensure a care plan was initiated related to the resident's urostomy for 1 of 1 resident reviewed with a urostomy. (Resident #83)</p> <p>Findings include:</p> <p>1. On 10/10/12 at 10:30 am., Resident #83's record was reviewed. The resident's diagnoses included, but were not limited to, cognitive communication deficit, urinary tract</p>	F0279	<p><u>Corrective Action</u> Resident #83 has had a care plan added to the medical record for the urostomy and the care plan for incontinence currently reflects that he is incontinent of bowel. The urostomy care plans was completed on 10-10-12 and this is addressed under "impaired skin integrity" and the incontinence of bowel care plan was updated on 10-10-12.</p> <p><u>Identification</u> Residents without appropriate care plans related to medical</p>	11/11/2012	

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	<p>infections, and sepsis. The resident was admitted on 9/21/12. The admission Minimum Data Set Assessment, dated 9/28/12, indicated the resident had a urostomy.</p> <p>The physician's order, dated 10/9/12, was routine urostomy care q (every) shift; change urostomy bag as needed and daily; dx (diagnosis): bladder cancer.</p> <p>No care plan was developed for the resident's urostomy. A care plan, dated 10/10/12, indicated the resident was incontinent of bowel and bladder. The interventions were to provide bed pan upon his request; incontinent care after each incontinent episode; keep call light within reach; check and change every 2 hours; barrier cream after each incontinent episode if ordered; and toilet per resident request and prn (as needed).</p> <p>2. On 10/8/12 at 10:22 a.m., a urinary leg bag with yellow liquid observed in the bag was observed on the back of the toilet in his room. The resident had a Foley catheter bag in place.</p> <p>On 10/9/12 at 9:15 a.m., the resident's Foley catheter bag was observed in a bag tied to the bar in</p>		<p>and/or care needs have the potential to be affected by this alleged deficient practice.</p> <p><u>System Change</u></p> <p>Care plans will be reviewed and/or updated to reflect the current resident needs within 14 days of readmission to facility.</p> <p><u>Monitoring</u></p> <p>The MDS Coordinator will conduct a facility wide care plan audit by 11-11-12. The MDS Coordinator will then conduct a facility wide care plan audit monthly times 3 months and quarterly times 3 quarters with the quarterly audit per the resident's MDS schedule. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>		

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	<p>the bathroom. The resident was observed in his room in his wheelchair with a leg bag in place draining cloudy, yellow urine.</p> <p>On 10/9/12 at 9:20 a.m., Resident #83 was observed eating breakfast in his room. His Foley catheter bag was in place with cloudy, yellow urine observed in his tubing and bag. A separate leg bag was observed in a bag in his bathroom.</p> <p>On 10/11/12 at 8:10 a.m., Resident #83's leg bag and measuring container was observed bagged in the same bag hanging in the bathroom on the hand bar.</p> <p>On 10/11/12 at 8:20 a.m. during an interview, the Director of Nursing indicated when the bag for Resident #83's urostomy was changed to a leg bag or Foley catheter, the previous bag used was to be thrown away.</p> <p>On 10/11/12 at 10:10 a.m. during an interview, RN #1 indicated Resident #83's urostomy dressing was completed on the night shift unless the dressing would become soiled.</p> <p>On 10/11/12 at 4:15 p.m. during an interview, the Director of Nursing indicated should probably have a care</p>			

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	<p>plan for his urostomy and its care.</p> <p>On 10/11/12 at 4:28 p.m. during an interview, the MDS (Minimum Data Set) Coordinator indicated Resident #83 should have had a care plan initiated for his urostomy.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a Midline (Central Intravenous Line) dressing was changed in accordance with facility policy for 1 randomly observed Midline dressing. (Resident # 64)</p> <p>Findings include:</p> <p>During an interview with Resident # 64 on 10/11/12 at 2:14 p.m., his Midline dressing was dated 9/29/12.</p> <p>On 10/11/12 at 2:30 p.m., during an observation with LPN # 15 of Resident # 64's Midline dressing, she indicated the dressing was dated 9/29/12 and should have been changed prior to 10/11/12.</p> <p>The record for Resident # 64 was reviewed on 10/11/12 at 3 p.m., and indicated the residents Midline was</p>	F0328	<p><u>Corrective Action</u></p> <p>Resident #64 had the Midline dressing changed on 10-11-12.</p> <p><u>Identification</u></p> <p>Residents that has a Midline dressing that is not changed according to physician orders and/or facility protocols has the potential to be affected by this alleged deficient practice. Licensed staff will be in-serviced on Midline dressing changes on or before 11/9/12.</p> <p>-</p> <p><u>System Change</u></p> <p>Residents with Midline dressings will have their dressing changed according to facility protocol and documented on the TAR (treatment administration record).</p>	11/11/2012			

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	<p>inserted on 9/29/12. The Medication Administration Record for October 2012 indicated the Midline dressing was scheduled to be changed on 10/8/12 and was not signed off as complete.</p> <p>A policy titled "Dressing Changes for Midline and Central Catheter" was provided by the Director of Nursing on 10/11/12 at 4:27 p.m. The policy indicated: "...3. Routine Dressing Change...b. The transparent dressing should be changed at least every 7 days...."</p> <p>3.1-47(a)(2)</p>		<p><u>Monitoring</u></p> <p>Residents having Midline dressings will have an audit of their TAR (treatment administration record) completed weekly for three months, monthly for three months and quarterly for 3 quarters. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>	

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure resident had diagnoses for the use of psychoactive medications, had documented behavioral symptoms for the use of psychoactive medications, had attempted non-chemical interventions before the use of psychoactive medications and had monitoring of blood sugars and administration of insulin in accordance with sliding scale orders for 4 of 10 residents reviewed for</p>	F0329	<p>Corrective Action Resident #87's Ativan was discontinued on 10-11-12. Resident #117 physician was contacted and a diagnosis of insomnia was given for use of the Valium. Resident had long term use of Valium for insomnia prior to admission. Resident was discharged to home on 10-22-12. Resident #83 did not have any identified issues/concerns/problems from receiving 8 Units of insulin instead of 4 Units of insulin per sliding scale on 9/27/12 or from</p>	11/11/2012			

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	<p>unnecessary medications (Residents #87, #117 #83 and #39)</p> <p>Finding Include:</p> <p>1.) Resident #87's record was reviewed on 10/10/12 at 2:45 p.m.</p> <p>Resident #87's current diagnoses included, but were not limited to, altered mental state and Alzheimer's disease.</p> <p>Resident #87 had a 9/6/12 physician's order for Ativan 0.25mg (an antianxiety medication) 1 tablet every 4 hours as needed due to agitation.</p> <p>Resident #87's record for 9/1/12 to 9/6/12 lack any documented behavioral indicators for the use of an antianxiety medication.</p> <p>Review of Resident #87's medication administration record for October (10/1/12 through 10/10/12) 2012 indicated she was given the as needed antianxiety medication Ativan as follows: 10/7/12, 4:00 p.m.; 10/7/12, 8:00 p.m.; 10/9/12, 9:00 p.m.</p> <p>Resident #87's record lacked: a.) a diagnoses for the use of the</p>		<p>lack of documentation related to blood sugars results and/or insulin coverage per sliding scale on 9/28/12, 10/5/12 or 10/6/12 as evidenced by skilled nursing notes with charting resident had no signs/symptoms of hypoglycemia and/or hyperglycemia. Resident #39 did not have any identified issues/concerns/problems related to elevated blood sugar and lack of documentation related to insulin coverage given and/or lack of insulin coverage given. <u>Identification</u> Residents that receive medications not according to their physician's orders do not have diagnosis and/or behaviors tracking in place for psychoactive medications have the potential to be affected by this alleged deficient practice. Licensed staff will be in-serviced on administering medications according to physician orders and on giving a snack when administering insulin prior to a meal service on or before 11/9/12. Licensed staff will be in-serviced on obtaining diagnosis for psychoactive medications, behavior tracking/monitoring/reporting on or before 11/9/12. <u>System Change</u> Residents with physician orders for psychoactive medications will have a diagnosis for use obtained from the physician when the order is received. If a diagnosis is not received with the order, the</p>				

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	<p>antianxiety medication Ativan</p> <p>b.) a description of the behavior that occurred prior to the administration of the above 3 doses of as needed Ativan in October 2012.</p> <p>c.) documentation of any non-chemical interventions attempted prior to the administration of the as needed Ativan in October 2012.</p> <p>During a 10/10/12, 4:30 p.m. interview, the Director of Nursing indicated the following:</p> <p>a.) Resident #87 had a symptom for Ativan but not a diagnoses</p> <p>b.) Resident #87 did not have any documented behaviors prior to the administration of the above 3 doses of as needed Ativan on October.</p> <p>c.) Resident #87 did not have any documented non-chemical interventions prior to the administration of the 3 doses of as needed Ativan in October.</p> <p>2.) Resident #117's record was reviewed on 10/10/12 at 12:00 p.m.</p> <p>Resident #117's current diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>Resident #117 was admitted to the facility on 10/1/12.</p>		<p>physician will be contacted for a diagnosis. Residents receiving psychoactive medications will have the appropriate behavior tracking in place to monitor the behaviors and/or nursing documentation will reflect the behavioral issues. MonitoringThe facility's clinical meeting (Monday through Friday) will review physician orders to ensure a diagnosis was obtained for psychoactive medications when the order was written. If diagnosis is not present, the nurse on the unit will be notified by the in-house system to contact the physician and obtain a diagnosis for use; the order will be reviewed for appropriate diagnosis at the next clinical meeting. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>		

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	<p>Resident #117 had a current 10/1/12 order for Valium 5 mg 1 tablet daily at bed time.</p> <p>Resident #117's record contained no diagnoses for the use of Valium.</p> <p>During a 10/10/12, 1:51 p.m. interview, the Administrator indicated the record did not contain a diagnoses for the use of Valium. The facility believes the resident used Valium for insomnia and would contact the physician to verify. The Administrator indicated verification of all medications and the diagnoses for their use should be completed shortly after admission.</p> <p>3.). On 10/10/12 at 10:30 am., Resident #83's record was reviewed. The resident's diagnoses included, but were not limited to, Diabetic Mellitus.</p> <p>The physician's orders, dated 9/21/12, was Novolog 100 units/ml (milliliter) per sliding scale subcutaneously 4 times a day. The sliding scale included, but was not limited to, the following: blood sugar of 201 to 250 = 4 units; 301 to 350 = 8 units.</p> <p>The "MEDICATION</p>			

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	<p>ADMINISTRATION RECORD" indicated the following: On 9/27/12 at 11:00 a.m., the blood sugar result was 239 with 8 units of insulin coverage given, not 4 units as ordered; On 9/28/12 at 8:00 p.m., no information was indicated for a blood sugar result and/or needed insulin coverage; On 10/5/12 at 4:00 p.m., the blood sugar was 246 with no information indicated insulin coverage was given; On 10/6/12 at 8:00 p.m., no information was indicated for a blood sugar result and/or needed insulin coverage;</p> <p>4.) On 10/10/12 at 10:05 am., Resident #39's record was reviewed. The resident's diagnoses included, but were not limited to, Diabetic Mellitus.</p> <p>The physician's rewrite orders, dated 10/4/12, included, but were not limited to, accuchecks 2 times a day with Novolog (Humalog) sliding scale coverage as follows: Blood sugar 150 to 250 = 3 units; 251 to 350 = 6 units and 351 to 450 = 9 units.</p> <p>The "MEDICATION ADMINISTRATION RECORD" for</p>				

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	<p>10/2012 indicated on 10/7/12 at 4:00 p.m. the blood sugar was 367 with no indication of the amount of insulin coverage given.</p> <p>On 10/11/12 at 2:15 p.m. during an interview, the Director of Nursing indicated she had no information related to the blood sugars and/or possible insulin coverage for Resident #83 or Resident #39.</p> <p>3.1-48(a)(3)</p>			

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observations, record review, and interview, the facility failed to ensure it remained free of a medication error rate of 5 % or greater for 3 of 50 opportunities for error observed during medication pass observation. The medication error rate was 6 %. (Resident # 64, #20 and # 42)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 10/10/12 at 9:01 a.m., LPN # 16 administered 2 puffs of Flonase in each nostril to the resident # 64.</p> <p>Record review on 10/10/12 at 9:34 a.m., indicated a physician orders dated 10/4/12 for one puff of the Flonase instead of 2. At this time during interview, LPN # 16 indicated the resident should have received one puff in each nostril instead of 2.</p> <p>2. During a medication pass observation on 10/10/12 12:01 p.m., LPN # 17 administered 28 units of Novolog insulin to Resident # 42. At</p>	F0332	<p><u>Corrective Action</u> Resident #64 did not have any unwanted effects and/or side effects from receiving 2 puffs of Flonase Resident #17 showed no signs/symptoms of hypoglycemia and/or hyperglycemia from receiving the insulin greater than 10 minutes prior to eating. Resident #20 had no unwarranted effects from receiving the Lovenox from 10/5/12 to 10/10/12. The resident's physician that controls the levels/dosage of anticoagulant medication was notified of the issues. The physician orders were rewritten on a separate MAR (medication administration record) after the physician was notified and orders were clarified.</p> <p><u>Identification</u> Residents that receives medications not according to their physician's orders have the potential to be affected by this alleged deficient practice. Licensed staff will be in-serviced on following medications per physician's orders and the administration time change of insulin dependant residents. Licensed staff have been in-serviced on the procedure of escorting the</p>	11/11/2012	

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	<p>this time, the LPN indicated she would get the resident her lunch tray since the resident ate in her room and room trays were served last. During interview on at 12:34 p.m., LPN # 17 was informed the resident had not received her lunch tray. She indicated she planned to pick up the tray at 12:30 p.m., but was a few minutes late.</p> <p>Review on 10/11/12 at 8:46 a.m., of the "Nursing 2011 Drug Handbook" located on the south nursing station, page 1064 indicated to give Novolog insulin 5-10 minutes before the meal.</p> <p>3. During a medication pass administration on 10/10/12 at 4:01 p.m., LPN # 18 administered Lovenox 120 mg by subcutaneous injection to Resident #20.</p> <p>The record for Resident # 20 was reviewed on 10/11/12 at 8:46 a.m. A physician order dated 10/5/12 indicated to start the Lovenox on 10/12/11. The Medication Administration Record for October 2012 indicated the Lovenox was administered daily from 10/5/12-10/10/12. During interview with RN #19 on this date at 8:50 a.m., she indicated the Lovenox should not have started on 10/5/12, but on</p>		<p>insulin dependant resident to the dinning room to ensure that meals are served within 10 minutes of administration of insulin coverage.. This will be completed by 11/9/12.</p> <p><u>System Change</u> Administrative nursing staff will randomly audit med pass to ensure that licensed staff are appropriately reviewing the MAR (medication administration record) to administer the correct doses per physician orders. The medication administration time has been changed to at the beginning of the meal service for residents receiving siding scale insulin coverage. Breakfast: 7:30am Lunch: 12:30pm Dinner: 5:30pm Licensed staff will escort the resident to the dinning room after administering the insulin and ensure that meals are served within 10 minutes of administration of insulin coverage.</p> <p><u>Monitoring</u> Administrative nursing staff will complete medication pass audits on at least one unit and one shift weekly times three months, monthly times three months and quarterly for three quarters. Any identified issues/concerns/problems will be reported to the QA committee for further</p>		

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	10/12/12 as the physician order indicated. 3.1-25(b)(9)		discussion/review and recommendations		

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observations and interview, the facility failed to ensure knowledge of maintaining the posted nursing staff data and timely posting of this information for 3 of 4 days observed during the annual survey.</p>	F0356	<p><u>Corrective Action</u> Facility staffing was posted as per regulation starting on 10-12-12.</p> <p><u>Identification</u> The facility is in non-compliance with regulations when the staffing is not posted as required. <u>System Change</u></p>	11/11/2012

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	<p>(October 9, 10, and 11, 2012)</p> <p>Findings include:</p> <p>On 10/9/12 at 7:40 am, the staff posting data was dated and included information for 10/8/12.</p> <p>On 10/10/12 at 8:00 am, the staff posting data was dated and included information for 10/9/12.</p> <p>On 10/11/12 at 7:35 a.m., the staff posting was dated and included information for 10/10/12.</p> <p>On 10/11/12 at 1:35 p.m. during an interview, the Staff Coordinator indicated she would post the staffing data after she arrived and obtained the census information. She indicated this was usually between 9:00 to 9:15 a.m. after the day shift had begun. She also indicated she was unaware of how long to keep the information.</p> <p>3.1-13(a)</p>		<p>The Staffing Coordinator will have the required staffing forms completed for the night shift prior to leaving the facility each day and on Friday for staffing Saturday through Monday. The night shift nurse will change the staffing form out at midnight to reflect the current staffing for the current day. Monitoring The Staffing Coordinator will check the posted staffing daily (Monday through Friday) to ensure that this is correct. The Administrator and/or designee will audit the posted staffing at least 2 times per week for 3 months, at least 2 times per month for 3 months and 2 times per quarter for the next 3 quarters. Identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>		

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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 observations, record review, and interview, the facility failed to ensure open dates for multidose medications were present</p>	F0431	<p><u>Corrective Action</u></p> <p>Expired and undated medications when opened were disposed of and</p>	11/11/2012			

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	<p>and narcotic medications were signed out when given for 3 of 4 medication carts. (West, East, 1 of 2 of South's medication carts)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 10/10/12 at 2:25 p.m. in the West medication room, the opened tuberculin purified protein (TB) multidose vial was observed in the refrigerator with no open date. RN #3 indicated she was not aware the TB medication had to be dated when opened On 10/11/12 at 12:30 p.m. with House Supervisor, the following medication carts were observed: <p>In the East medication cart, 3 of 9 opened insulin multidose vials did not have an opened date. During the narcotic count, Resident #25's oxycodone (pain medication) had not been signed out when given; Resident # 48's alprazolam's count was incorrect. At this same time during an interview, LPN #5 indicated she had given the larger dose of alprazolam 0.5 mg (milligram) ordered for the p.m. dose as the a.m. dose, which should had been alprazolam 0.25 mg.</p>		<p>new medications were ordered for the affected resident's medications.</p> <p><u>Identification</u></p> <p>Expired medications that could potentially be used for residents has the a potential</p> <p>Any resident that receives expired medications or medications that have not been dated when opened to determine the expiration date have the potential to be affected by this alleged deficient practice. Licensed staff will be in-serviced dating medications when opened and checking for expired medications on or before 11/9/12.</p> <p><u>Monitoring</u></p> <p>The facility will conduct a medication room and medication cart audit for expired and undated medications when opened weekly for three months, monthly for three months and quarterly for three quarters. Identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2012	
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The West medication cart had 3 of 7 multidose insulin vials with no open date. Five of ten multidose eye drops had no open dates.</p> <p>As the narcotic count was completed with the House Supervisor on the first South medication cart, RN #6 was observed to go through the narcotic count book on the second South medication cart and sign out at least 3 different resident's narcotic medications, which she indicated she had given this a.m.</p> <p>3. The "CONTROLLED MEDICATIONS POLICY" was provided by the Director of Nursing on 10/11/12 at 12:10 p.m. This current policy indicated the following:</p> <p>"...Procedures</p> <p>...D. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR):</p> <ol style="list-style-type: none"> 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>the dose, completed after the medications is actually administered....."</p> <p>The "EXPIRATION DATES OF PERISHABLE MEDICATION AS OF 01/01/05" was provided by the DON on 10/11/12 at 2:55 p.m. This current policy indicated the following: Multi-dose injectable products expired 30 days after opening; ophthalmic preparations expired 90 days after opening; Recommended minimum medication storage parameters were for insulin products was to discard 28 days after opening and Tuberculin test (TB test) was to date when opened and discard unused portion after 30 days.</p> <p>3.1-25(j)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2012	
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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>Based on observations, interview, and record review, the facility failed to</p>	F0441	<u>Corrective Action:</u>	11/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2012	
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
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	<p>ensure infections control practices were followed related to handwashing for 1 of 4 CNA's observed (CNA #7) for 2 of 3 resident's observed receiving oral fluids (Resident #119 and #64) and related to equipment handling and storage for 6 of 37 rooms observed and 1 of 1 pill counter observed. (Room #'s 121, 119, 313, 319, 307, 83 and 106 and West medication cart pill counter)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 10/9/12 at 8:07 a.m., Room 106 was observed. In the bathroom the call light string was observed on the floor. <p>On 10/9/2012 at 9:18 a.m. Room 319 was observed. In the bathroom, an uncovered graduated container was on the bathroom floor with the call light string on dragging on the floor.</p> <p>On 10/9/2012 at 9:24 a.m., Room 307 was observed. In the bathroom a wash basin and graduated container were both observed uncovered and on the floor. Also, an uncovered fracture bedpan was observed stored in the wall arm brace next to the toilet.</p> <p>On 10/9/12 at 12:55 p.m., Room 319</p>		<p>The resident rooms identified by the surveyors have been further inspected by the Environmental Director and the Administrator</p> <p>Identification:</p> <p>Residents have the potential to be affected by this alleged deficient practice when infection control practices/protocols are not followed.</p> <p>Staff will be in-serviced on Hand washing on or by 11/9/12</p> <p>Nursing and Housekeeping staff will be in-serviced on or by 11-9-12 on placement of resident toileting equipment when not in use</p> <p>System Change:</p> <p>A Preventive Maintenance schedule for resident's room inspections has been added to the program.</p> <p>The check list used will identify that the cords for call lights and wall lights are inspected on a monthly bases. . Effective 10/29/12. Any issues identified will be corrected at the time of the inspection.</p> <p>Inspection of residentrooms will be completed by 11/30/12.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>was observed. In the bathroom, an uncovered fracture pan was placed in the hand bar next to the toilet.</p> <p>On 10/9/2012 at 1:39 p.m., Room 313 was observed. In the bathroom, the call light string was observed on the floor. Also, the graduated container was observed uncovered and sitting on the bathroom floor.</p> <p>2. On 10/8/12 at 1:10 p.m., CNA #7 entered Resident #64's room and assisted him with setting up his meal tray when she was observed to cough into her hands. After she left the room, CNA #7 was observed to handwash for less than 10 seconds, turned the water off with her wet hand, and then, dried her hands. She then retrieved from the kitchen an ice tea for Resident #119 and Resident #64's chocolate milk and served the drinks to them.</p> <p>On 10/10/12 at 11:02 a.m. during an interview, CNA #7 indicated one should handwash for 20 seconds, which was singing Happy Birthday 2 times and to shut the water off with a paper towel after drying one's hands.</p> <p>4. On 10/10/12 at 2:25 p.m. during the narcotic count, RN #3 was observed to count 1 bottle of</p>		<p>A Housekeeping daily cleaning schedule has been put in place by 10/29/12. The check list includes documentation that all equipment has been removed from the floor in the bathroom.</p> <p>Monitoring:</p> <p>The Assistant Housekeeping Director will randomly inspect and document the finding on an audit sheet for at least 3 rooms per hall per week, for a total of 9 rooms weekly. This inspection will continue to be in place.</p> <p>The Environmental Director will review with the Administrator the documented inspections of the resident rooms on weekly bases for 1 month, then monthly there after.</p> <p>The Administrator and/or designee will complete an inspection of 9 rooms completed on a weekly basis for 1 month and thereafter random inspections on amonthly basis.</p> <p>Any continuing identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>medication with the pill counter followed by a second different medication with the pill counter. No cleansing between the 2 different medication counts were observed. On 10/11/12 at 12:53 p.m. during an interview, RN #1 indicated the pill counter should be cleansed between 2 different medications.</p> <p>5. On 10/8/12 at 10:22 a.m. in Resident #83's room, an uncovered urinary leg bag with yellow liquid observed in the bag was observed on the back of the toilet in his room. The resident had a Foley catheter bag in place.</p> <p>On 10/9/12 at 9:15 a.m., Resident #83's Foley catheter bag was observed in a bag tied to the bar in the bathroom. The resident was observed in his room in his wheelchair with a leg bag in place draining cloudy, yellow urine.</p> <p>On 10/9/12 at 9:20 a.m., Resident #83 was observed eating breakfast in his room. His Foley catheter bag was in place with cloudy, yellow urine observed in his tubing and bag. A separate leg bag was observed in a bag in his bathroom.</p> <p>On 10/11/12 at 8:10 a.m., Resident</p>			

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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		
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	<p>#83's leg bag and graduated container was observed bagged in the same bag hanging in the bathroom on the hand bar.</p> <p>6. On 10/11/12 at 10:18 a.m. during an interview, the Director of Nursing and RN #1 indicated when the bag for Resident #83's urostomy was changed to a leg bag or Foley catheter, the previous bag used was to be thrown away. The Director of Nursing also indicated the graduated container should be thrown away after each use.</p> <p>On 10/11/12 at 9:27 a.m., CNA #7 indicated Resident #83's urine bags should be thrown away after use.</p> <p>7. The "DISINFECTION OF BEDPANS AND URINALS" policy was provided by the Director of Nursing (DON) on 10/11/12 at 4:32 p.m. This current policy indicated the following:</p> <p>"...B. PROCEDURE</p> <p>...12. Cover and return bedpan or urinal to resident's bedside cabinet....."</p> <p>The "DISINFECTION OF MEASURING GRADUATES" policy</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was provided by the DON on 10/11/12 at 4:32 p.m. This current policy indicated the following:</p> <p>" ...PROCEDURAL GUIDELINES:</p> <p>...7. A separate graduated container (which is marked with resident's name and room number) should be used to empty the urine for each resident. This graduate should be discarded and a new one supplied each day,"</p> <p>The "HANDWASHING" policy was provided by the House Supervisor on 10/11/12 at 4:45 p.m. This current policy indicated the following:</p> <p>"STANDARD</p> <p>The facility will provide guidelines and approved supplies to all employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections.</p> <p>...Handwashing Procedure</p> <p>...2. Rinse hands thoroughly under running water...</p> <p>3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel....."</p>			

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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 10/8/12 between 10 a.m.-12 p.m., the following was observed:</p> <p>Room 121's bathroom had one uncovered bedpan on the floor by the toilet and one bedpan sitting on the trash can.</p> <p>Room 119's bathroom had bowel movement on the commode riser and there was a wash basin under the sink on the floor with a hair brush in the basin.</p> <p>3.1-18(l) 3.1-19(f)</p>				

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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		
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F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review the facility failed to maintain resident rooms, resident restrooms, and common areas in a clean orderly state of good repair for 28 of 37 resident rooms reviewed for environmental cleanliness and repair (Rooms 103, 105, 106, 107, 108, 110, 111, 112, 113, 117, 119, 121, 125, 127, 201, 202, 203, 206, 209, 211, 302, 304, 306, 307, 313, 315, 319 and 321) and the common areas of the therapy room, 300 hallway, 300 shower room, front door entry area.</p> <p>This deficient practice had the potential to impact the 57 residents who could reside in 28 rooms identified above. This deficient practice had the potential to impact the 24 residents who could reside and shower on the 300 hall. This deficient practice impacted 3 of 3 units (East, West and South) and had the potential to impact 60 of 60 residents who resided in the facility.</p> <p>Findings include:</p>	F0465	<p><u>Corrective Action:</u> The resident rooms identified by the surveyors have been further inspected by the Environmental Director and the Administrator. <u>Identification:</u> Residents have the potential to be affected by the alleged deficient practice. The facility has been inspected and problem areas identified by the Administrator and the Environmental Director. Carpet has been identified as needed replace in 6 resident rooms.</p> <p><u>System Change:</u> A Preventive Maintenance schedule for resident's room inspections has been added to the program. This schedule includes a check list that will inspect resident rooms on a monthly base, effective 10/29/12. Any issues identified will be corrected at the time of the inspection. Resident rooms will be completed by 11/30/12. The common areas, Therapy room and restrooms will be completed by 12/15/12 A Housekeeping daily cleaning schedule has been put in place. Additional attention and detail has been given with an added weekly check list for effective cleaning. This will be completed by 11/11/12. Example: Monday-High dusting Tuesday-Low dusting</p>	11/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>During a 10/11/12, 9:30 a.m. environmental tour accompanied by the Maintenance Supervisor observed concerns included but were not limited to the following :</p> <p>a.) The front door to the facility had a sticky glue across the threshold. The glue substance was attracted dust, dirt and other materials. This glue strip left a strip of residue across the threshold. At the entryway, the grout between the baseboard tiles was missing.</p> <p>b.) The wall outside room 311 was cracked from the ceiling down to the door frame.</p> <p>c.) The short west wall in the therapy room had wallpaper which was coming apart at the seam and revealing the drywall underneath. The therapy room had a section where a floor strip had been removed leaving a sticky residue which attracted dust and residue.</p> <p>d.) The 300 hall shower had a strong mildew odor. There was dark black mildew on the shower chair. The shower floor near the wall had a heavy black mildew. The walls where not painted after items had been removed revealing dry wall and patches of varied colored</p>		<p>Wednesday-Bathroom floors and gout Thursday-Window sills and Curtains Friday Wash trash cans and de-lime faucets. The carpet identified in 6 resident rooms is scheduled to be replaced over a 3 month period with 2 being completed monthly per agreement with Hochstedler Floor covering. Completion by end of January 2013. See attached estimate, signed purchase order and schedule of replacement by the end of January 2013 Monitoring: The Assistant Housekeeping Director will randomly inspect and document the finding on an audit sheet for at least 3 rooms per hall per week, for a total of 9 rooms. The Environmental Director will review with the Administrator the documented inspections of the resident rooms on weekly bases for 1 month, then monthly there after. The Administrator and/or designee will complete an inspection of 9 rooms completed on a weekly bases for 1 month and then random inspections monthly there after. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>paint.</p> <p>e.) The South Hall Nursing Station was missing Formica around the edge exposing pressed wood beneath.</p> <p>During 10/8/12 and 10/9/12 resident room observations identified concerns included, but were not limited to the following:</p> <p>Room 125, 10/8/12, 10:33 a.m. The feeding pump had dried formula running down the side of the pump and the pole. The wall by the sink was chipped with exposed dry wall beneath. The bathroom floor had a gray black film around the floor where the floor met the wall. Up the tile of the wall had a gray black residue up the grout about 1 to 2 inches throughout the bathroom. The clean grout above the area was white.</p> <p>Room 202, 10/8/12, 11:22 a.m. There was a large area of red brown substance resembling rust on a 3 by 4 foot square approximately 4 foot from the head board. There was a red brown substance forming a 3 foot circle under the sink. The bathroom floor had a gray black substance around the base board. This gray black substance was in the grout up</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2012
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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>the wall about 1 to 2 inches throughout the bathroom. The grout above the substance was white.</p> <p>Room 209, 10/8/12, 3:52 p.m. The wall upon entering the room was scared and marred with white and black/gray scratches that exposed the drywall beneath. The bathroom smelled of mildew. The bathroom floor had a gray/black substance rimming the wall and extending up the wall 1 to 2 inches throughout the bathroom. The half-wall located between the 2 beds in the room was marred on the bottom half exposing drywall and metal framing. The wall paper near the sink was loose and torn exposing the drywall beneath.</p> <p>Room 211, 10/8/12, 3:37 p.m. The half-way separating the 2 beds was chipped and marred exposing the drywall beneath and metal frame. The wallpaper by the sink was torn exposing drywall. The closet door was marred all the way across.</p> <p>Room 206, 10/9/12, 9:13 a.m. The wallpaper under the sink was torn and revealed the drywall beneath.</p> <p>Room 127, 10/8/12, 10:39 a.m. The call light cord to the door bed had</p>			

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NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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	<p>dark brown residue over 1/3 of the cord. The wall by the restroom door was marred with black, gray and white scratches which exposed the drywall. cove board trim was missing near the closet. The chest of drawer was missing finish around the top edge. The wall by the sink was chipped and marred exposing drywall and a metal frame.</p> <p>Room 201, 10/8/12, 10:56 a.m. The built in chest of drawers had a 4 inch by 4 inch piece of coating chipped off exposing the pressed wood. The half-wall which separated the 2 beds was chipped and marred with black scratches. The marring exposed the drywall. The bathroom floor had a gray black residue around the edge and up the wall.</p> <p>Room 302 On 10/08/2012 at 12:10 p.m., Room 302 was observed. Gray loose pieces were observed in the entire bottom of her bed light. In the bathroom, the rubber piece at the door threshold was loose exposing the floor tiles underneath it. The caulking around the toilet was observed dark brown to black in appearance.</p> <p>Room 321 On 10/08/2012 at 4:11 p.m., Room</p>			

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	<p>321 was observed. In the bathroom, the bathroom sink was observed with 4 screws spaced apart above the sink with 1/2 of each screw protruding over the top of the sink.</p> <p>Room 106 On 10/09/2012 at 8:07 a.m., Room 106 was observed. The light above the bed had 1 bottom light burned out. In the bathroom upon entering, the wall had various areas measuring 6 to 12 inches of paint scraped off and exposing the dry wall located on the bottom half of the wall and above the baseboard under the sink.</p> <p>Room 304 On 10/09/2012 at 9:08 a.m., Room 304 was observed. As one entered the bathroom, areas of exposed unpainted white wall substance measuring 3 to 6 inches in length was observed in the bottom of the wall.</p> <p>Room 307 On 10/09/2012 at 9:24 a.m., Room 307 was observed. In the bathroom, the sink was observed with a 1/4 inch gap between the wall and the sink with areas of drywall visible on the wall. In her room next to her bed, no cover was on the vent area of the air conditioner with white pieces of debris in the opened vent area. The</p>			

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	<p>wallpapers was loose at the wallpaper seams on one side below the outside window closest to the bathroom.</p> <p>Room 111 Room 111's bathroom wall 12-18 inches up from the floor was marred and chipped around the right wall and the wall under the sink and toilet.</p> <p>Room 106 Room 106's carpet was stained throughout the room. The bathroom wall on the right side of the door was chipped and marred 12 inches up the wall. The sink was pulling away form the wall on the right side. The privacy curtain was hanging off of 7 hooks.</p> <p>Room 121 Room 121's bathroom tile floor was soiled throughout. The window curtain was hanging off of 2 hooks. The internal bathroom door was scuffed and marred 12-18 inches up the door. The wall on the on right side of the room had scuffing and marring from the closet to bathroom door 12-18 inches up the wall.</p> <p>Room 110 Room 110's bathroom hot and cold</p>			

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	<p>water handles were broken and had hard water build up. The tile floor was soiled with dark spots throughout. The bathtub was soiled and had a bath basin, box of gloves, 2 hangers and 2 pieces of paper in the bottom. The caulking around the tub was brown with some pieces missing. The cove board was pulling away from the wall by the closet.</p> <p>Room 119 Room 119's bathroom tile floor was soiled throughout.</p> <p>Room 108 Room 108 had brown splatters on the built in dresser drawers (4), and there was no cove board behind toilet.</p> <p>Room 117 Room 117's bathroom sink cold water handle base was cracked and coated with hard water build up and the hot water handle did not have a metal base. The over the sink light fixture was hanging on the left side. The wall paper on the right and left hand side of the wall by the built in dresser had wallpaper and cove board that was pulling away from the wall. The trim on the television shelf was chipped and marred in two places.</p> <p>Room 114</p>				

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	<p>Room 114's bathroom sink water handles had hard water build up.</p> <p>Room 103 Room 103's bathroom sink hot water handle was cracked and had hard water build up.</p> <p>Room 107 Room 107's carpet had large stained spots throughout the room. The bathroom floor had debris around the cove board. There was an empty oxygen water bottle on the floor under the over the bed table at the foot of the bed. On 10/9/12 at 8:30 a.m., the empty bottle of water for the oxygen tank remained on floor at the foot of the bed.</p> <p>Room 112 Room 112's bathroom tile floor was soiled throughout.</p> <p>Room 113 Room 113's privacy curtain was hanging off 10 hooks. The bathroom sink hot water handle had hard water build up and the wall in 3 spots had chunks out of the dry wall at the cove board.</p> <p>Based on a 10/8/12, 10:30 a.m. observation, the facility had 3 units</p>			

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	<p>East (100), West (300) and South (200).</p> <p>Review of the "Bed Inventory" form completed by the Administrator on 10/8/12 indicated 57 residents could potentially reside in the 28 rooms identified with concerns above and 24 residents could potentially reside on the 300 hall and use the 300 hall shower room.</p> <p>During a 10/11/12, 10:00 a.m. interview, The Maintenance Supervisor indicated the walls in the facility which were scared and marred needed repair. The resident bathroom floors and shower room with residue on the floor and up the wall were in need in deep cleaning. Personal care items should not be left laying about and should be stored properly.</p> <p>During a 10/11/12, 10:37 a.m. interview the, Maintenance Supervisor indicated it was he goal for each resident room to receive a deep cleaning one time each month.</p> <p>Review of a current, undated, facility form titled "Deep Cleaning Check List", which was provided by the Maintenance Supervisor on 10/11/12 at 10:37 a.m. included the following:</p>				

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	<p>"Bathroom: walls washed...floors mopped"</p> <p>Review of a current, 11/1/11, policy titled "Deep Cleaning Resident Rooms", which was provided by the Maintenance Supervisor on 10/11/12 at 10:37 a.m. included the following: "Clean Bathrooms and Toilets: ...sponge mop floors with germicidal... Cleaning of Lavatories: ...Spray all metal, such as faucets, stoppers and drains.. Rinse both porcelain and metal with wet clean cloth..."</p> <p>Review of a current, 11/1/11, facility policy titled "Housekeeping frequency Scheduling and Job Assignment", which was provided by the Maintenance Supervisor on 10/11/12 at 10:37 a.m. included the following: "Example Work Assignment" "7:20-7:40-Inspect all resident rooms for heavy soil A. Spot clean all resident bathrooms B. Spot clean all resident room floors."</p> <p>3.1-19(f)</p>						

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F0468 SS=C	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. Based on observation and interview, the facility failed to ensure all hallways were equipped with handrails on each side for 1 of 3 units reviewed (300 hall). This deficient practice had the potential to impact 60 of 60 residents.</p> <p>Finding include:</p> <p>During a 10/11/12, 9:30 a.m. environmental tour accompanied by the Maintenance Supervisor, the 300 hallway wall from the therapy room to the drinking fountain was observed to have a decorative chair-rail style trim but no handrail. This area measured over 5 feet in length. During an 10/11/12, 9:40 a.m. interview, the Maintenance supervisor indicated the 5 foot area outside the therapy room had never had a handrail and had only the trim since the current side rails were put in place many years prior.</p> <p>During observations on 10/8/12 from 10:00 a.m. to 4:00 p.m. residents from every unit (100, 200, and 300) were</p>	F0468	<p><u>Corrective Action:</u> The diagonal wall outside of therapy room has been identified as needing a handrail.</p> <p><u>Identification:</u> Residents have the potential to be affected by this alleged deficient practice.</p> <p><u>System Changes:</u> A new handrail will be installed by 11/11/12.</p> <p><u>Monitoring:</u> The handrails will continue to be inspected monthly according to the Preventive Maintenance Program. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p>	11/11/2012	

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	observed to travel the 300 hallway outside the therapy room. 3.1-19(f)(3)				