

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 28, 29, 30, April 2, 3, 2012</p> <p>Facility number: 000054 Provider number: 155126 AIM number: 100287850</p> <p>Survey team: Carole McDaniel, RN- TC Terri Walters, RN Martha Saull, RN March 29, 30, April 2, 3, 2012 Dorothy Watts, RN</p> <p>Census bed type: SNF NF 66 Total 66</p> <p>Census Payor type: Medicare 12 Medicaid 48 Other 6 Total 66</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 10,</p>	F0000		
-------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	2012 by Bev Faulkner, R.N.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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
F0159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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>in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide prompt access to resident funds on week-ends for 3 of 3 residents interviewed from a sample of 5 residents with personal funds in facility accounts. Resident 60, 95, 16 .</p> <p>Findings include:</p> <p>In interview on 3/28/2012 at 2:50 P.M., Resident # 95 indicated he could not access his money on Saturday or Sunday.</p> <p>In interview on 3/28/2012 at 3:40 P.M., Resident # 16 indicated you can access your money from the business office during the week, but the Business Manager is not available week ends.</p> <p>On 3/28/201, at 2:00 P.M., Resident #60 indicated he did not have access to his personal funds on the week</p>	F0159	<p>1. Facility will formulate internal policy to facilitate prompt access to resident funds on evenings/weekends. Education will be provided to Resident #60, #95, #16 on new process. 2. 100% inservice to all residents with resident trust accounts to new process. 3. 100% inservice to all licensed nursing personnel on new process for providing prompt access to resident funds. 4. Process for attaining funds will be provided to new admissions at time of entering facility and reviewed monthly at resident council meetings. Business Office Assistant will follow up with those residents not attending monthly resident council meeting, which have resident trust accounts, and forward on to resident council president. Resident council meetings will be forwarded to centers Quality Performance Improvement meeting monthly for analysis and review. 5. Systemic changes will be completed by May 2, 2012.</p>	05/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432		
(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>ends.</p> <p>On interview on 4/2/2012 at 2:45 P.M., the Business Manager indicated the residents who needed money on weekends asked the nurse on the shift and she was to notify the Administrator (HFA) about the requested funds. The HFA then called the Business Manager and notified her about the request for funds from a resident. The Business Manager was then arrange to come to the facility and disperse the funds to the resident. There was no petty cash fund available to provide reasonably prompt access to personal funds for residents.</p> <p>On 4/2/2012 at 4:21 P.M., RN # 3 indicated when a resident requested funds, the RN called the HFA. The HFA then notified the Business Manager of the request for funds. The Business Manager subsequently was to then come to the facility to disperse the requested funds to the resident.</p> <p>Facility policy and procedure reviewed on 4/3/2012 at 3:00 P.M., indicated Resident Funds should be available 7 days a week.</p> <p>3.1-6(f)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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			
F0203 SS=C	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on interview and record review, the facility failed to ensure transfer or discharge information had been provided to the resident upon transfer or discharge from the facility for 3 of 3 residents reviewed for transfer and discharge. Resident # 48, Resident # 49, and Resident # 58. This deficient practice had the potential to affect all residents transferred or discharged from the facility.</p> <p>Findings include:</p> <p>On 4/3/12 at 12:50 P.M., Resident #48, #49, and #58's clinical records were reviewed for notice of transfer or discharge. On 4/3/12 at 12:55 P.M., the Social Service Director (SSD) was interviewed regarding lack of discharge/transfer notice in the</p>	F0203	<p>1. Inservice to all licensed nursing personnel on use of Notice of Transfer/Discharge Form and Appeal Rights. 2. All pending transfer/discharges will be approved by either HFA/DON/ADON . Nursing floor personnel will be instructed again at that time to initiate proper forms and place copies on chart. 3. Review of chart following next business day for proper form copies applied to chart during daily clinical review. 4. Implementation of Medical Records Discharge Tracking Form to be completed in order to ensure proper documentation is given to resident upon transfer/discharge. Any trends/ issues will be forwarded monthly to Quality Performance Improvement meeting for analysis and review. Any noted non-compliance by facility licensed nursing personnel will result in 1:1 re-education with</p>	05/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432		
(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>clinical records for Resident #48, #49, and #58 upon transfer from the facility to the hospital.</p> <p>On 4/3/12 at 1:10 P.M., the Business Office Manager was interviewed. She indicated the facility had found the State Department of Health form titled, "Notice of Transfer or Discharge." She indicated the facility had not been using this form. She indicated the facility had not implemented this form but will now start using the form immediately. She indicated the facility will inservice the nursing staff how to use this form.</p> <p>3.1-12(a)(6)(A)</p>		<p>progressive discipline as deemed appropriate. 5. Systemic changes will be completed by May 2, 2012.04/27/12</p> <p>Addendum:3. DON or Designee will be reviewing transfer/discharged charts the next business day for proper documentation of Transfer/Discharge Form and Appeal Rights.4. Medical Records Clerk will be responsible for completing the Discharge Tracking Form and forward on to the DON or Designee for review in clinical review daily.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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			
F0247 SS=A	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure notification of a roommate change for 1 of 3 residents reviewed for a change in roommates. Resident # 75</p> <p>Findings include:</p> <p>On 4/3/12 at 11:35 A.M., the Social Service Director (SSD) was interviewed. She indicated Resident # 102 had recently been admitted (3/3012) into a room with Resident #75. The SSD indicated at this time that Resident #75 had not been given written notification of a new roommate. She indicated the facility does not have a form related to resident notification in regard to a new roommate. She indicated she does not document in the clinical record the notification of a roommate change.</p> <p>On 4/3/12 at 11:40 A.M., the clinical record of Resident # 75 was reviewed. Resident #75's nursing notes and social service notes lacked documentation of notification of a new</p>	F0247	<p>1. Social Services Director was educated on providing written documentation in the clinical record of current resident, in a double occupancy room, in regard to a new roommate. Resident # 75 was interviewed for any issues/concerns with current roommate. No issues/concerns noted. 2. 100% audit of all double occupancy rooms to ensure no issue/concerns with current roommate arrangements. 3. Upon any new admission entering facility, entering double occupancy room, Social Services will notify current resident in room of planned addition of roommate and document conversation in the Social Services section of record regarding notification of a new roommate. 4. Upon receiving notification of new admission, HFA/DON will follow-up with Social Services in daily triage meeting to ensure that proper written documentation has been provided regarding notification of a new roommate. 5. Systemic changes will be completed by May 2, 2012.</p>	05/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

	roommate. 3.1-3(v)(2)			
--	------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432		
(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	
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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication errors were less than 5 % in that 3 medication errors were observed during 52 opportunities for error in medication administration. This resulted in an error rate of 5.76 %. Resident # 8, Resident # 36, Resident #86</p> <p>Findings include:</p> <p>1. On 3/30/12 at 7:51 A.M., LPN # 3 after preparation of Resident #86's 8:00 A.M., medications, administered Resident #86's 8:00 A.M., medications. These medications included the drug, Omeprazole DR 20 mg.</p> <p>On 3/30/12 at 8:30 A.M., Resident #86's March 2012's physician orders were reviewed. These orders included the order for Omeprazole DR 20 mg 1 capsule to be given orally once a day. This order included but was not limited to the instructions "take before food/meal."</p> <p>2. On 3/30/12 at 8:14 A.M., LPN #3</p>	F0332	<p>1. Resident #8,#36, #86 were reviewed for discrepancies of medication labeling instructions vs. Medication Administration times. Immediate correction actions were completed. LPN #3 & # 5 re-educated on proper administration of medications according to recommendations on label for resident #86 and #8 and #36. 2. 100% audit of all medications that are ordered "before meals" to ensure that administration times on Medication Administration Record's are correct. 3. Inservice to licensed nursing personnel on administration of medications as prescribed with attention to pharmacy labeling vs. printed times on Medication Administration Record.4. Medical Records clerk to review Medication Administration Record's monthly during change over process for accuracy of administration times.Any trends/ issues will be forwarded and reviewed in monthly Quality Performance Improvement meeting.5. Systemic changes will be completed by May 2, 2012.04/27/12 Addendum2. There will be observations three times per week of medication pass for all shifts.</p>	05/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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>after preparation of Resident #8's 8:00 A.M., medications, administered Resident # 8's 8:00 A.M., medications. These medications included the drug, Omeprazole DR 20 mg .</p> <p>On 3/30/12 at 8:35 A.M., Resident #8's clinical record was reviewed. Resident # 8's March 2012 physician's orders included the order for Omeprazole DR 20 mg (Prilosec), 1 capsule to be given orally once a day. This order included but was not limited to the instructions "take before food/meal."</p> <p>On 3/30/12 at 9:15 A.M., LPN #3 was made aware the medication, Omeprazole, was to be given before a meal. LPN #3 indicated she was aware that Resident #8 and #86 had eaten their breakfast before the Omeprazole had been given and that this was a problem.</p> <p>3. On 4/2/12 at 8:18 A.M., LPN #5 after preparation, administered Resident # 36's 8:00 A.M., medications. These medications include the drug, Omeprazole DR 20 mg.</p> <p>On 4/2/12 at 8:35 A.M., Resident #36's clinical record was reviewed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432		
(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>Resident #36's March 2012 physician's orders included the order for Omeprazole DR 20 mg, 1 capsule to be given orally once a day. This order included but was not limited to the instructions "take before food/meal." During interview with LPN # 5, at this time, she indicated Resident #36 had consumed her breakfast before the Omeprazole had been given.</p> <p>On 4/3/12 at 12:10 P.M., the facility's 2012 Lippincott's Nursing Drug Guide was reviewed in regard to the medication Omeprazole (Prilosec). On page 896 in regard to the drug Omeprazole teaching points included but were not limited to: "Take the drug before meals..."</p> <p>On 4/3/12 at 12:15 P.M., the Director of Nursing (DON) was made aware of the medication, Omeprazole, being given after breakfast had been consumed by Resident's #8, #36, and #86. She indicated she was aware of the problem. She indicated her nurses had already told her.</p> <p>3.1-48(c)(1) 3.1-25(b)(9)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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			
F0441 SS=D	<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>Based on observation, interview and record review, the facility failed to</p>	F0441	1. 1:1 re-education with RN #1 on infection control measures while	05/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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>provide preventive infection transmission practices during medication pass by 1 of 6 nurses observed administering medication to 1 of 10 residents. RN #1, Resident #111</p> <p>Findings include:</p> <p>On 4/02/2012 at 10:00 A.M., RN # 1 was observed to go to her medication cart to prepare medications to administer to Resident #111. RN #1 did not wash her hands before beginning. She prepared the medication in a plastic medication cup and poured water into a plastic glass containing a straw. She handed the medication in the cup to the resident. Resident #111 put the cup to her mouth poured the medication onto to her tongue and handed the empty cup back to RN #1. As the resident was drinking water from the glass and swallowing the medication, RN#1 stood at the bedside with the med cup on her right palm circling the rim of it (which had been in the resident's mouth) with her fingers. She took the glass and straw from the resident. The RN returned to the med cart with the medication cup and the drinking cup and straw that the resident had used. She placed these items on the supposedly</p>		<p>dispensing medications to residents. 2. Inservice to licensed nursing personnel/QMA's regarding infection control practices and universal precautions during medication administration. 3. DON/ADON to preform random infection control survellaince during medication administration times 2 weeks. Any continued issues noted with infection control will be addressed individually with licensed nurse/QMA and progressive disciplinary action resulting as deemed appropriate and forwarded to Quality PerformanceImprovement meeting monthly.4. Monitoring of infection control practice will be completed quarterly with facility completeion of Medication Administration Observation Task.5. Systemic changes will be completed by May 2, 2012.04/27/12 Addendum:3. DON or designee to perform randon infection control survellaince which will be coducted three times per week on all shifts for no less than 10 Licensed Personnel observed passing medications.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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>clean medication cart surface. The mouth end of the straw was touching a roll of bandage tape, which was hung on the handle of the pill crusher. The nurse then handled items in her pocket, getting her pen and recorded data in the medication administration book atop the cart, opening the book and working through it to find the correct page. She then threw out the cup, put medication cart keys in her pocket and went to the nurses' station to dispose of the water in the cup and toss it in the waste can. She then washed her hands in the nurses station sink. When interviewed regarding hand sanitizing products available on the medication cart or her person she indicated she did not have any.</p> <p>The related 1999 Policy and Procedures (revised April 2012) for handwashing indicated the staff were to wash hands between resident personal contact and directly after being contaminated.</p> <p>The Director of Nursing was informed of the observation on April 3, 2012 at 1:00 P.M., and indicated the nurse was not adhering to facility standard of practice.</p> <p>3.1-18(b)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012	
NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(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			
F0514 SS=B	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure weights were accurately documented for 2 of 3 residents reviewed in the sample of 20 who met the criteria for nutrition. Resident #103, Resident #96</p> <p>Findings include:</p> <p>1. The clinical record of Resident #103 was reviewed on 3/30/12 at 9 A.M.</p> <p>The "Weight Detail Report" was reviewed on 3/30/12 at 10 A.M., for Resident #103. This report indicated the following documented weights in pounds for 2012: 2/1: 190.6 lb; 2/3: 190.6 lb.; 2/7: 175 lb.; 3/6: 176.5; 3/12: 183.3.</p>	F0514	<p>1. Resident #13 & #96 were evaluated for any adverse effects from weight discrepancies noted. No adverse effects noted. 2. 100% audit of all residents from 4/3/12 forward for weight gain/loss of 3% or greater and evaluated as specified by Clinical Programs Policy 10.1.1- Weight Monitoring. 3. Inservice to all licensed nursing personnel on Clinical Programs Policy 10.1.1- Weight Monitoring. Inservice to Dietary Manager and Assistant Dietary Manager on Clinical Programs Policy 10.1.1- Weight Monitoring. 4. DON to monitor all residents for weight gain/loss of 3% or greater and request to re-weigh residents with +/- 3% for accuracy. Weight changes of 3% or more will be reviewed in Daily Triage Meeting and possible follow-up at the Daily Clinical Review Meeting. 5. Systemic changes will be completed by</p>	05/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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 4/2/12 at 3:55 P.M., the DON (Director of Nursing) was interviewed. She was made aware of the resident's documented 15 pound (lb) weight (wt) loss in 4 days, from 2/3 to 2/7. The DON (Director of Nursing) indicated the resident should have been reweighed after the lower weight was documented on 2/7.</p> <p>On 4/3/12 at 9:10 A.M., the Nutrition Risk Data Collection and Assessment was reviewed. This form indicated the following: "Diseases and Conditions Affecting Nutrition: cardiovascular disease, hypertension, coronary artery disease, diabetes..."</p> <p>On 4/3/12 at 9:15 A.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure titled "Weight Monitoring." This policy was dated "effective April 2010." This policy included, but was not limited to, the following: "...requires measured and recorded weights to assure accuracy..." The procedures included, but were not limited to, the following: "...weigh...until accuracy has been verified by the licensed nurse; weigh...until the weight is determined to be stable by the interdisciplinary team...weigh...monthly to monitor</p>		<p>May 2, 2012.04/27/12 Addendum:4. DON will monitor the Residents' weight gain and or loss monthly for all Residents requiring monthly weights, weekly for all of those requiring weekly weights and daily for those Residents requiring daily weights, and then forwarded to clinical review daily as required.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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>stability...report the weight to the Licensed Nurse. Weight will be verified for accuracy by the Licensed Nurse. Licensed Nurse Responsibilities: verify accuracy of the weight by comparing the weight with the most recently recorded weight. Compare weights...to determine 3% weight change...monitor weight reports for significant changes..."</p> <p>On 4/3/12 at 9:20 A.M., the DON was interviewed. She indicated the resident had been admitted on 1/26/12 with a weight of 180.9 lb. On 2/1/12, the weight report indicated the resident weighed 190.6 lb. The DON indicated at this time, the above documented weight increase in 6 days was a 5 percent increase and the resident should have been reweighed. She also indicated at this time, the weight on 2/3 of 190.6 lbs as compared to the next documented weight of 175 lb was a 7.5 percent weight loss. She indicated the resident should have been reweighed at this time. She indicated documentation was lacking of reweights. The DON indicated at this time, a resident with a 3 percent weight gain or loss should be reweighed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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>2. The clinical record of Resident #96 was reviewed on 3/30/12 at 1 P.M.</p> <p>A "Nutrition Risk Data Collection and Assessment" form, dated 1/31/12, indicated the following: "Dysphagia [difficulty swallowing] with nectar thick liquids, also on tube feeding bolus."</p> <p>On 3/30/12 at 1:00 P.M., the "Weights Detail Report" was reviewed. This form included but was not limited to the following: 1/31/12: 100.6 lb; 2/7/12: 96 lb; 3/20/12: 106 lb; 3/27/12: 100.2 lb.</p> <p>On 4/2/12 at 1:00 P.M., the DON was interviewed. She indicated Resident #96 received Osmolyte bolus feedings through a G-tube (gastrostomy), but was also encouraged to consume foods orally. At this time, she was made aware of the weights as documented on 1/31 to 2/7 and 3/20 to 3/27. She indicated these weights as documented indicated a 5 % weight loss in a week's time period and this resident should have been reweighed. She indicated documentation was lacking of this resident being reweighed. She indicated residents with a 3 percent weight gain or loss should be reweighed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3.1-50(a)(2)			