| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 02/11/2015 |
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| NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041 | |

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| F000000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey Dates: February 4, 5, 6, 9,10, and 11, 2015<br><br>Facility Number: 000192<br>Provider Number: 155295<br>AIM Number: 100291120<br><br>Survey Team:<br>Maria Pantaleo, RN-TC<br>Rita Mullen, RN<br>Bobette Messman, RN<br><br>Census bed type:<br>SNF : 6<br>SNF/NF: 77<br>Total: 83<br><br>Census payor type:<br>Medicare: 12<br>Medicaid: 56<br>Other: 15<br>Total: 83<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review was completed by Tammy Alley RN on February 16, 2015. | F000000 | **This plan of correctionis the facility's credible allegation of compliance. Preparation and/or executionof this plan of correction does not constitute admission or agreement by the provider of the truth of the facts allegedor conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw. The facility is requesting a deskreview in place of a revisit survey.** | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| F000246 SS=E | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br>Based on observation,record review and interview, the facility failed to provide a call bell within reach of the resident for 5 of 83 residents observed for the call bell light location (Residents # 14, 23, 41, 95, and 105 ).<br><br>Findings included:<br><br>1.) During an observation on 2/6/2015 at 9:00 a.m., resident # 95 was sitting in her chair asleep with the call bell light on the bed behind the chair and not within reach for the resident.<br><br>2.) During an observation on 2/6/2015 at 10:56 a.m., resident # 105 was in bed with the call bell light at the foot of the bed, not within reach for the resident.<br><br>3.) During a tour of the facility with the Director of Nursing on 2/9/2015 at 1:45 p.m., the following were observed: | F000246 | **F246 Reasonable accommodation ofneeds/preferences**<br>·Residents# 14, 23, 41, 95, and 105's call bells were immediately placed within reach ofthe resident.<br>·Residentswho have decreased or limited ability or mobility have the potential to beaffected by this alleged deficient practice.<br>·Nursingstaff will be in-serviced on the policy and procedure of call light system andavailability (exhibit "A"). The Director of Nursing and or designee will randomlyaudit placement of call lights twice a day three days a week for one month,once a day 3 days a week for one month, once a day two days a week for four months (exhibit "A"). Non compliancewill be addressed through re-education and progressive disciplinary actions asindicated. Results of audits will be reviewed monthly in QA&A monthly for 6months and then quarterly thereafter. | 03/13/2015 |

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| | a.) Resident # 14 was in bed with the call bell light on the floor at the foot of the bed, not within reach for the resident.<br><br>b.) Resident # 41 was in the chair with the call bell light on the bed, not within reach of the resident.<br><br>c.) Resident # 23 was in bed with the call bell light at the foot of the bed, not within reach for the resident.<br><br>During an interview with the Director of Nursing on 2/9/2015 at 3:00 p.m., she indicated the residents should have had their call bell lights within reach for easy access and utilization. She indicated Residents #105,#14,#41, and #23 needed assistance for mobility.<br><br>The policy titled "Call Light, Use of", no date of origin, received on 2/9/2015 at 2:55 p.m., from the Director of Nursing, indicated "...8. When providing care to the residents be sure to position the call light conveniently for the resident to use...."<br><br>3.1- 3(v)(1) | | | |
| F000278<br>SS=D | 483.20(g) - (j)<br>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>The assessment must accurately reflect the resident's status. | | | |

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| | A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement. | | | |
| | Based on record review and interview, the facility failed to correctly code a resident on Hospice as having a prognosis of six months or less on the Minimum Data Set (MDS) assessments for 1 of 1 resident reviewed for Hospice. (Resident #38).<br><br>Findings include:<br><br>The clinical record of Resident #38 was reviewed on 2/9/15 at 9:00 a.m. | F000278 | **F 278 Assessmentaccuracy/coordination/certified**<br>·Resident# 38 no longer resides in facility; however, a modification has been made and submitted forresident # 38.<br>·Residentswho are currently or in the future have hospice services have the potential tobe affected by this alleged deficient practice.<br>·MDScoordinator will be re-educated on the importance of accuracy of the MDS andits | 03/13/2015 |

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| | Diagnoses included but were not limited to: End Stage 1 Liver Disease, chronic persistent hepatitis, cirrhosis, and sepsis.<br><br>Resident #38 was admitted to Hospice on 11/26/14 with Hospice diagnosis of End Stage 1 Liver Disease. The Physician order for hospice was on 11/26/14.<br><br>A Significant Change MDS (Minimum Data Set) assessment was completed on 12/1/14. Resident #38 was identified as a hospice resident but was not identified as having six months or less in the MDS documentation.<br><br>During an interview with MDS Coordinator on 2/9/15 at 10:15 a.m. , she indicated a significant change can be done within 14 days and Resident #38 did have physician documentation to indicate admission to hospice services with a 6 months or less prognosis.<br><br>3.1-31(g) | | purpose. Director of Nursing or designee, will audit change of conditionMDS' for accuracy as they occur for 6 months (exhibit "B") Non compliance willbe addressed through re-education and progressive disciplinary action asindicated. Results of audits will be reviewed monthly in QA&A monthly for 6months and then quarterly thereafter. | |
| F000329<br>SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>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 | | | |

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| | consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>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. | | | |
| | Based on record review and interview, the facility failed to accurately and completely monitor and track depressive behaviors for 1 of 5 residents reviewed for unnecessary (Resident #102).<br><br>Findings include:<br><br>The clinical record of Resident #102 was reviewed on 2/11/15 at 11:00 a.m. Diagnoses included, but were not limited to, anoxic brain damage, depression, anxiety and diabetes.<br><br>A review of the Medication Administration Record (MAR), for the months of December 2014, January 2015 and February 2015, indicated Resident #102 was receiving Zoloft (an antidepressant) 50 mg (milligrams) daily and lorazapam (an antianxiety) 0.5 mg | F000329 | **F 329 Unnecessary Drugs**<br>·Resident#102 was assessed and has shown no adverse effects from PRN medication given.Social Service note date 2/4/2015 at 4:30 indicates resident was “calm”.<br>·Residentswho receive antipsychotic medications have the potential to be affected by thisalleged deficient practice.<br>·Nursingstaff will be re-educated on the behavior monitoring program in electronicmedical record (SigmaCare), i.e.: using non medical interventions, giving PRNmedications, and follow up with effectiveness (exhibit “C”).<br>Director of Staff Development or designee, willdaily run “effectiveness and follow up” report daily to ensure nursing staffhave documented correctly (exhibit “C”). Non compliance will be addressedthrough | 03/13/2015 |

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| | daily.<br><br>A review of the electronic "Administration Documentation History Detail Report," for the months of December 2014, January 2015 and February 2015, indicated the targeted behaviors monitored for the use of lorazapam were restlessness, anxious, worried facial expression, repetitive verbalizations, hyperventilation and unrealistic fear. The targeted behaviors for the use of Zoloft were crying, withdrawn and sad facial expression. Targeted behaviors recorded were as follows:<br><br>For Zoloft 50 mg there was one episode in January 2015 and two episodes in February 2015.<br><br>For lorazapam 0.5 mg there were five episodes in December 2014, four in January 2015 and two in February 2015.<br><br>The "Behavior Monitoring Log" dated for the months January 2015 and February 2015, indicated Resident #102 did not have targeted behaviors during the months of January 2015 and February 2015. Resident #102 did have episodes of exit seeking on 2/4/15 at 1:30 p.m. and 2/4/15 at 4:00 p.m. There was no December 2014 behavior log. | | re-education and progressive disciplinary actions as indicated. Resultsof audits will be reviewed once a week for one month in QA&A, monthly for 6months and then quarterly thereafter. | |

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| | During an interview with the Social Service Director, on 2/11/15 at 3:00 p.m., she indicated she was not informed Resident #102 was having behaviors during the month of December 2014 and she didn't initiate a "Behavior Monitoring Log."<br><br>A review of the MAR for the month of February 2015, indicated lorazapam 0.5 mg PRN (as needed) was administer on 2/4/15 at 1:21 p.m. There was no assessment as to the effectiveness of the PRN lorazapam.<br><br>During an interview with the Executive Director, on 2/11/15 at 3:55 p.m., he indicated no record of the effectiveness of the PRN lorazapam was found in the resident's record.<br><br>A Policy for "Psychoactive Medication Management," dated August 2014, received from the Executive Director, on 2/11/15 at 3:30 p.m., indicated the following:<br><br>"...It is the policy of this facility that residents in need of psychotherapeutic medication receive appropriate assessment and intervention in order to achieve their highest practicable level of functioning.... | | | |

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| | 3. When psychoactive medications are prescribed for a specific condition or targeted behavior, the clinical record will be reflective of the diagnosis, reasons for use (functional impairment)....The effectiveness of these medications and non-drug approaches should be regularly documented in the nursing notes....<br><br>8. Medication effects will be monitored and documented on the medication administration record, to include targeted behavior monitoring, and monitoring for adverse effects when the medications are used...."<br><br>3.1-48(a)(4) | | | |
| F000425<br>SS=D | 483.60(a),(b)<br>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. | | | |

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| | The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on observation, record review and interview the facility failed to provide the accurate labeling of medication for 1 of 9 residents observed during medication administration. (Resident # 25)<br><br>Findings include:<br><br>During an observation of medication administration on 2/9/2015 at 4:45 p.m., resident # 25 was given 1 Gabapentin (an antiepileptic) 300 mg (milligrams) capsule by LPN #1.<br><br>The MD (Medical Doctor) order indicated give 1 Gabapentin 300 mg capsule by oral route (by mouth) 2 times per day (BID) .<br><br>The pharmacy medication label on the card containing the medication for administration indicated give 1 Gabapentin 300 mg capsule three times a day (TID).<br><br>During an interview on 2/9/2015 at 5:10 p.m., with LPN #1, she indicated the pharmacy medication card was incorrect and should have been corrected at the time of delivery. | F000425 | **F425 Pharmaceutical SVC-AccurateProcedures, RPH**<br>·Resident# 25 had no adverse affects. Medication card was marked with a “directionchange” sticker immediately and new card ordered from pharmacy and had beendelivered that evening.<br>·Residentswho reside in facility and who receive medications from pharmacy has thepotential to be effected.<br>·Nursingstaff will be re-educated on the policy and procedures on “Receiving andlogging medications from outside pharmacy” (exhibit “D”). Nurse Managers willaudit all medication cards against orders in electronic medical record toensure accuracy of orders and administration direction on card. Director of Staff Development or designee willreconcile orders with cards 5 times a week (exhibit “D”). Non compliance willbe addressed through re-education and progressive disciplinary actions asindicated. Results of audits will be reviewed weekly for one month in QA&A,monthly for 6 months and then quarterly thereafter. | 03/13/2015 |

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| | The pharmacy medication card indicated 12 capsules had been received by Resident # 25.<br><br>A record review on 2/10/2015 at 11:00 a.m., of the medication administration record (MAR), indicated the resident had received a Gabapentin 300 mg capsule BID since January 1, 2015.<br><br>During an interview on 2/10/2015 at 9:15 a.m., with the Director of Nursing, she indicated the pharmacy medication card should have been reviewed at the time of delivery, pharmacy notified and a "direction change refer to chart" label should have been applied to pharmacy medication card. She indicated this procedure had been completed 2/9/2015 when the discrepancy was discovered during medication administration.<br><br>The policy titled "5.1 Delivery and Receipt of Routine Deliveries," dated 12/1/2007, revised 01/01/2013, received from the Director of Nursing on 2/11/2015 at 1:30 p.m., indicated "... 2.4 Inspect the package(s) for damage or errors and notify Pharmacy as soon as possible but within twenty-four (24) hours ...."<br><br>3.1-25(k)(5) | | | |

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| F000465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 6 of 30 resident rooms (walls, floors, doors, bathroom fixtures and furniture), (Room's # 211, 214, 411, 413, 415, and 602), 1 of 1 hallway in the 700 secure unit and 1 of 30 resident rooms observed for odors, (Room # 415). This deficient practice had the potential to impact 11 of 83 residents utilizing rooms in the facility and 16 of 16 residents living in the secure unit.<br><br>Findings include:<br><br>1. During the initial tour on 2/4/2015 at 9:31 a.m., the following were observed:<br><br>a.) The 700 hallway wall between rooms # 707 and # 709 was gouged, chipped and peeling.<br><br>b.) The 400 hallway entering from the common area had a urine odor near room #415.<br><br>2. During resident room observations on 2/4/2015, 2/5/2015, and 2/6/2015 the following were observed: | F000465 | **F465Safe/Functional/Sanitary/Comfortable Environment**<br>·Allareas identified were corrected by the maintenance supervisor/housekeepingsupervis or in order to meet the regulation of maintaining residents' rooms andcommon areas in clean and orderly state of repair and free of odor.<br>·Residentswho live in the facility have the potential to be affected by this allegeddeficient practice.<br>·TheExecutive Director and the Maintenance Director or designee, will complete anaudit of resident care areas and common areas to identify any areas that arenot in good repair and those areas will be repaired. The Maintenance Director ordesignee will develop a monthly schedule of painting door frames and a parttime painter will be employed. The painter will paint door frames twice a monthand stain doors as needed. The Housekeeping Supervisor or designee willcomplete and audit weekly all rooms and identify any areas of concern. Roundswill be made by the Housekeeping Supervisor or designee, 5 times weekly (exhibit"E")to identify areas any of concern or odor. These audits will be reviewed atthe end of each | 03/13/2015 |

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| | a.) Room 211 on 2/5/2015 at 9:45 a.m., a silver dollar size gouge on the bedroom wall near the closet door, the wallpaper was peeling off the wall and the closet doors were chipped, marred and peeling .<br><br>b.) Room 214 on 2/5/2015 at 3:20 p.m., the bathroom wall was chipped and peeling, the toilet bowel had shifted off the tile on the bathroom floor, the wall above the bathroom door was cracked, and the wallpaper was peeling off the wall in the bathroom.<br><br>c.) Room 411 on 2/4/2015 at 2:52 p.m., the bathroom walls were chipped and peeling, the bathroom tile had shifted and was uneven around the toilet, and the closet doors were marred, chipped and peeling.<br><br>d.) Room 413 on 2/4/2015 at 3:01 p.m., the bedroom walls and closet doors were chipped, marred, and peeling.<br><br>f.) Room 415 on 2/5/2015 at 11:09 a.m., the wallpaper was peeling from the ceiling, the bedroom walls were marred, chipped, gouged, and peeling, the bathroom door was marred, scratched and chipped, 10 nails were located in the wall above the bed, closet doors were marred, chipped and gouged, and the room had a | | business day. Housekeeping and Maintenance audits will bereviewed weekly for 2 months in QA&A and monthly thereafter. Non compliancewill be addressed through re-education and progressive disciplinary actions asindicated. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 02/11/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041 | |

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|---|---|---|---|---|
| | urine odor.<br><br>g.) Room 602 on 2/6/2015 at 8:35 a.m., the closet doors were marred and gouged, chipped and peeling.<br><br>3. During the environmental tour, on 2/9/2015 at 2:00 p.m., with the Administrator and Housekeeping Supervisor, the following were observed:<br><br>a.) Room 415 had a urine odor.<br><br>b.) Room 602 had an overhead vent that was rusted and dirty with dirt and the bedroom wall corner was chipped, marred and peeling.<br><br>During the environmental tour on 2/9/2015 at 2:00 p.m., with the Administrator and the Housekeeping Supervisor , the Administrator indicated a work request system was in place and all staff are aware how to request repairs in the facility.<br><br>The Administrator indicated he was not aware the resident rooms needed repair, and the work request system did not include these rooms.<br><br>The Housekeeping Supervisor was aware room #415 had urine odors and the room had been cleaned twice each day. | | | |

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| | During a tour of the facility on 2/10/2015 at 2:35 p.m., with the Director of Nursing, she indicated room # 415 had a urine odor.<br><br>During an interview, on 2/11/2015 at 10:45 p.m., with the Administrator, he indicated the facility had been working on fixing the urine odor in room #415, but nothing tried had worked and the residents room continued to have a urine odor.<br><br>3.1-19(f) | | | |