

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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
F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 26, 27, 28, 29 &amp; 30, 2015.</p> <p>Facility number: 000388 Provider number: 155807 AIM number: 100454140</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicaid: 37 Other: 3 Total: 40</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction is to serve as Rural Health Care's credible allegation of compliance</p> <p>Submission of this plan of correction does not constitute an admission by Rural health Care or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care or other services in the facility Nor does this submission constitute an agreement or admission of the survey allegations</p>	
F 156 SS=A Bldg. 00	<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</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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 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: A description of the manner of protecting personal funds, under paragraph (c) of this section;  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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>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 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 interview and record review, the facility failed to issue a liability and appeal notices in a timely manner, when required, to 2 of 2 Medicare beneficiaries reviewed for liability and appeal notices. (Residents #12 &amp; #31)</p>	F 156		06/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>Findings include:</p> <p>1. The clinical record for Resident #31 was reviewed on 4/28/15 at 10:30 a.m. He was admitted to the facility on 12/15/14 from the hospital, on Medicare.</p> <p>During an interview with the Administrator, on 4/27/15 at 1:45 p.m., he indicated the facility did not provide a liability and appeal notice to Resident #31/Responsible Party.</p> <p>A Quarterly MDS (minimum data set) assessment, dated 2/14/15, indicated all therapy services ended 2/13/15 for Resident #31.</p> <p>2. The clinical record for Resident #12 was reviewed on 4/28/15 at 10:35 a.m. She was admitted to the facility on 11/16/14 from the hospital, on Medicare.</p> <p>An Advance Beneficiary Notice of Noncoverage (liability and appeal notice) indicated Resident #12's services ended on 1/9/15. The document was signed by Resident #12 on 1/15/15.</p> <p>The Administrator indicated, on 4/28/15 at 10:44 a.m., the Advance Beneficiary Notice of Noncoverage was not provided to Resident #12 prior to the end of her</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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
F 280 SS=D Bldg. 00	<p>Medicare coverage. The Administrator further indicated the Notice should be provided 2 days prior to termination of services.</p> <p>A policy titled, Notice of Medicare Provider Non-Coverage, no date, was received from the Administrator on 4/28/15 at 10:42 a.m. The policy indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNFs)...not later than 2 days before the termination of services...."</p> <p>3.1-4(f)(3)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was updated for a wandering behavior for 1 of 5 residents reviewed for medication related behavior monitoring. (Resident #5)</p> <p>Findings include:</p> <p>Resident #5's record was reviewed on 4/28/15 at 12:18 p.m. The resident's diagnoses included, but were not limited to, psychosis, dementia with aggression, PVD, chronic kidney disease, adult failure to thrive. The resident's medications included, but were not limited to, zyprexa, and remeron.</p> <p>A 12/18/14 MDS assessment indicated Resident #5 did not exhibit wandering behavior.</p> <p>A nursing note, dated 3/14/15, indicated Resident #5 was "...wandering in other res (residents) rooms and is easily redirected..."</p> <p>A 3/18/15 MDS assessment indicated Resident #5 had a BIMS (Brief Interview for Mental Status) score of "09" which</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> <li>The facility's care plans were audited for behaviors and all care plans were updated as needed. Care plan was updated to include resident wandering for resident identified.</li> <li>An audit will be completed on all residents identified as having behaviors to ensure care plans are up to date and accurate. Any care plans that are deficient will be updated at the time of review.</li> <li>MDS Coordinator was reinserviced on timeliness of comprehensive care plans. The SSD will educate employees on the facility's behavior documentation policy upon hire. SSD will also re-educate the facility staff quarterly on the facility's behavior documentation policy.</li> <li>DON will audit weekly that new admission charts, quarterlies and significant change MDS' have updated comprehensive care plans completed on time once per week for three months.</li> <li>Findings will be reviewed in QAPI monthly for three months, if continued concerns with comprehensive care plans are noted, will continue to review for another 3 months.</li> </ol>	06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>indicated the resident had a cognitive impairment. The assessment indicated behavioral symptoms, including wandering, were not present for Resident #5 during the review period of the assessment.</p> <p>A Hospice nursing progress note, dated 3/18/15, indicated Resident #5 "...believes he is still in jail. Now wandering in other pt's (patients) rooms..."</p> <p>On 4/27/15 at 11:22 a.m., during an observation, Resident #5 was in a wheelchair and entered Resident #16's room. Resident #16 stated, "You have to turn around (Resident #5), this is not your room."</p> <p>On 4/29/15 at 9:43 a.m., during an interview, Hospice nurse #7 indicated Hospice CNA's reported Resident #5 continued to wander into other residents rooms. She also indicated Resident #5 had displayed physically aggressive behaviors, such as poking staff. She indicated facility staff reported these behaviors verbally to her.</p> <p>On 4/29/15 at 10:20 a.m., during an interview with LPN #3, she indicated Resident #5 has been known to slap or "hit at" staff and wander into other</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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
F 465 SS=E Bldg. 00	<p>resident's rooms occasionally, and she recalls the behaviors have tended to be on "second shift." She indicated it may be a "sundowners" type behavior.</p> <p>On 4/30/15 at 9:52 a.m., RN #4 indicated Resident #5 "wanders" (in his wheelchair) into other residents rooms and the issue has been identified by nursing staff as a typical behavior of the resident.</p> <p>On 4/30/15 at 10:06 a.m., during an interview, the Social Services Director and MDS Coordinator indicated Resident #5's current care plans did not include interventions to address the resident's behaviors of wandering into other resident's rooms.</p> <p>A facility policy titled "CARE PLANS-Comprehensive" and dated August 2006 indicated Resident #5's care plans should be revised as "...changes in the resident's condition dictate..."</p> <p>3.1-35(d)(2)(B)</p> <p>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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>Based on observation and interview, the facility failed to maintain bathroom doors, door frames, and a wall in proper condition, and to maintain water temperatures between 100 and 120 degrees Fahrenheit for 22 of 40 residents in the facility. (Residents #2, #3, #5, #6, #9, #12, #14, #16, #17, #18, #21, #25, #26, #27, #28, #31, #33, #36, #38, #39, #42, and #45)</p> <p>Findings include:</p> <p>1. An initial tour of the facility was conducted on 4/26/15 at 4:45 p.m. Resident #25's bathroom door frame was chipped along the bottom corner.</p> <p>An environmental tour was conducted with the Maintenance Director on 4/30/15 at 10:10 a.m. An observation was made of Resident #25's chipped frame on the bathroom door frame. There was also a hole found in the bathroom the size of a softball behind the toilet on the back wall and the baseboard trim in which runs along the base of the floor was coming away from the wall. The Maintenance Director indicated at this time he could repair the hole on the back wall.</p> <p>2. During an observation on 4/27/15 at 9:27 a.m., Resident #42's bathroom door frame was chipped, and the bathroom</p>	F 465	<p>F465 1. The Administrator and Maintenance Director toured and audited the facility to identify environmental issues. The doorframes for the facility have been ordered and will be installed immediately upon arrival. The water temps were checked and adjusted by the maintenance director to meet state guidelines.</p> <p>2. There were no other deficiencies noted at the time of tour.</p> <p>B. The Maintenance Director conducted an audit of the water temperatures throughout the facility. The Maintenance Director will adjust the temperature as needed to ensure the water temperatures are within state guidelines</p> <p>3. The Maintenance Director will be re-educated on water temperatures and environmental rounds. The maintenance director will check water temps on a weekly basis ongoing. The maintenance director will be provided with an environmental rounds audit tool to be completed weekly, the Administrator will conduct these rounds with maintenance.</p> <p>4. A. The Admin or designee will conduct bi-weekly rounds to locate any environmental deficiencies throughout the building for one month, then weekly for one month and then monthly ongoing and a plan will developed for resolving concerns identified. B. The Administrator or his designee will also audit the</p>	06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>door had a piece of wood nailed to it, which was coming off the door on the left side corner with the screw still attached to the piece of wood, that had pulled away from the door.</p> <p>During an environmental tour with the Maintenance Director on 4/30/15 at 9:00 a.m., he indicated he could not nail the piece of wood back onto the door, because it was a fire door, nor could he remove the piece of the wood from the door. He indicated the piece of wood was to cover part of a damaged door. The damaged door could not be observed behind the piece of wood.</p> <p>3. During an observation on 4/27/15 at 1:37 p.m., Resident #17's bathroom door inside frame had pulled away from the wall, with a sharp metal piece sticking out.</p> <p>4. During an observation on 4/27/15 at 1:39 p.m. Resident #39's bathroom door frame had pulled away from the wall with metal sticking out.</p> <p>During an environmental tour with the Maintenance Director on 4/30/15 at 9:00 a.m., he indicated the bathroom doors and door frames needed to be replaced by a contractor, and was waiting for the approval to replace the doors and the</p>		<p>water temperature logs to ensure that they are within state guidelines. These audits will be conducted weekly for the first 8 weeks then monthly thereafter. 5. Results will be reviewed in QAPI monthly for monthly for three months. Water temps that are deemed out of state guidelines will be rectified, environmental issues that arise will have a plan in place as to completion time of each project.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>door frames.</p> <p>5. During a random observation on 4/27/15 at 9:16 a.m., Resident #33's water temperature in the sink was taken. The reading was 97.7 degrees Fahrenheit.</p> <p>During a random observation on 4/27/15 at 9:51 a.m., Resident #38's water temperature in the sink was taken. It was 97.7 degrees Fahrenheit.</p> <p>During a random observation on 4/27/15 at 10:28 a.m., Resident #27 indicated the water does not get hot enough. She would like for it to be a little warmer.</p> <p>During an environmental tour with the Maintenance Director on 4/30/15 at 9:00 a.m., the following water temperatures were taken in these residents' rooms:</p> <p>Residents #18, #26, and #33's bathroom sink water temperature was 76.8 degrees Fahrenheit.</p> <p>Residents #12, #14, #27, and #28's bathroom sink water temperature was 87.8 degrees Fahrenheit.</p> <p>Residents #3, #36, #38, #42's bathroom sink water temperature was 79.5 degrees Fahrenheit.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>Residents #2, #9, #16, and 21's bathroom sink water temperature was 77.5 degrees Fahrenheit.</p> <p>Residents #5, #6, #31, and #45's bathroom sink water temperature was 81.8 degrees Fahrenheit.</p> <p>During this time the Maintenance Director indicated the facility had three water heaters. The laundry room used one, and the other two were used by the kitchen and the rest of the facility. The water heaters were not big enough to maintain the water temperatures at 100 degrees in the residents' rooms when the kitchen was using hot water during meal times.</p> <p>During an environmental tour with the Maintenance Director on 4/30/15 at 10:10 a.m., the following water temperatures were rechecked for these residents:</p> <p>Residents #18, #26, and #33's bathroom sink water temperature was 100.2 degrees Fahrenheit.</p> <p>Residents #12, #14, #27, and #28's bathroom sink water temperature was 105.6 degrees Fahrenheit.</p> <p>Residents #3, #36, #38, #42's bathroom</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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
F 514 SS=A Bldg. 00	<p>sink water temperature was 103.1 degrees Fahrenheit.</p> <p>Residents #2, #9, #16, and 21's bathroom sink water temperature was 99.5 degrees Fahrenheit.</p> <p>Residents #5, #6, #31, and #45's bathroom sink water temperature was 102.2 degrees Fahrenheit.</p> <p>During this time the Maintenance Director indicated the water temperatures were higher, because the kitchen was not using the hot water. The kitchen would begin to use the hot water at lunch time, which would be at 11:00 a.m. At that time, the residents' water temperatures in their rooms would again decrease.</p> <p>3.1-19 (f)(5) 3.1-19 (r)(1)(2)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>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 observation, interview, and record review, the facility failed to document a resident's behaviors according to a resident's care plan and facility policy for 1 of 15 residents whose records were reviewed. (Resident #5)</p> <p>Findings Include:</p> <p>Resident #5's record was reviewed on 4/28/15 at 12:18 p.m. The resident's diagnoses included, but were not limited to, psychosis, dementia with aggression, PVD, chronic kidney disease, adult failure to thrive. The resident's medications included, but were not limited to, zyprexa, and remeron.</p> <p>A nursing note, dated 3/14/15 indicated Resident #5 was "...wandering in other res (residents) rooms and is easily redirected..." No other nursing notes between 2/28/15 and 4/3/15 indicated the resident had behavioral symptoms.</p> <p>A 3/18/15 MDS assessment indicated Resident #5 had a BIMS (Brief Interview for Mental Status) score of "09" which indicated the resident had a cognitive impairment.</p>	F 514	<p>F514 1. Resident's charts notes and facility behavior documentation book was audited to ensure that behaviors are being captured. 2. All residents have the potential to be effected by the deficientpractice. 3. The SSD will educate new employees on the facility's behavior documentation policy upon hire. SSD will also re-educate the facilitystaff periodically on the facility's behavior documentation policy. 4. Findings will be reviewed in QAPI meeting for 3 months.</p> <p>1. The facility inserviced all facility staff on Resident Rights. 2. All residents have the potential to be effected by the facility'sdeficient practice. 3. New employees will be educated on resident's rights during new hireorientation. All employees will be educated on resident's rights annually thereafter. 4. The Administrator or his designee will ensure all facility staff complete the inservice training. The Administrator will keep an accurate log of completed inservices to ensure that all staff are trained</p>	06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>A physician's order, dated 4/3/15, indicated for Resident #5's Zyprexa dosage to be increased from 2.5mg to 5mg daily for "(increased) psychosis"</p> <p>A 3/25/15 Hospice nursing progress note indicated Resident #5 had an increase in "...inappropriate behaviors..."</p> <p>A 4/1/15 Hospice nursing progress note indicated Resident #5 "...can be aggressive (at) times in his interaction (with) female staff (grabbing buttocks) but pt (patient) can also be easily redirected and pt has not been physically aggressive in a harmful manner..."</p> <p>A 4/8/15 Hospice nursing note indicated Resident #5 engaged in "...increased inappropriate behaviors (with) other residents..."</p> <p>On 4/28/15, during an interview with the ADON, he indicated Resident #5 is on Zyprexa for physically and verbally aggressive behavioral episodes, including grabbing staff members.</p> <p>On 4/28/15 at 1:48 p.m., during an interview with the SSD, she indicated Resident #5 was having "aggressive behaviors" around the time of 4/3/15, the date of the increased dosage of Zyprexa.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>A care plan for psychotropic medication use, dated 3/31/15, indicated "...If behavioral symptoms are observed, record and document on a 'Behavioral Tracking Form' "</p> <p>On 4/29/15 at 9:43 a.m. a Hospice nurse indicated she has been reported to by Hospice CNA's who indicated Resident #5 continued to wander into other residents rooms. She indicated not believing the Zyprexa medication has been effective in reducing adverse behaviors for the resident. She indicated having a plan to discuss medication changes with the resident's physician at an upcoming plan of care meeting. She also indicated Resident #5 had displayed physically aggressive behaviors, such as poking staff. She indicated facility staff reported these behaviors verbally to her.</p> <p>On 4/29/15 at 10:20 a.m., during an interview with Resident #5's LPN, she indicated the resident is on Zyprexa for physically aggressive behaviors such as poking staff with his finger and other behaviors. She indicated staff would normally document such findings in nursing notes and in the behavior log. She indicated the resident has been known to slap or "hit at" staff and wander into other resident's rooms occasionally, and she recalls the behaviors have tended</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>to be on "second shift." She indicated it may be a "sundowners" type behavior.</p> <p>On 4/30/15 at 9:52 a.m., Resident #5's RN indicated the resident wandered (in his wheelchair) into other residents rooms and the issue has been identified by nursing staff.</p> <p>On 4/30/15 at 10:06 a.m., during an interview, the Social Services Director and MDS Coordinator indicated Resident #5's current care plans did not include interventions to address the resident's behaviors of wandering into other resident's rooms.</p> <p>On 4/30/15 at 9:49 a.m., during an interview, the DON indicated the facility nursing staff has been "having a problem" documenting repetitive behavioral episodes by residents each time they occur. She indicated each behavioral episode should be documented on the facility behavior logs or in nursing notes.</p> <p>On 4/30/15 at 12:32 p.m., during an interview, RN #4 indicated Resident #5 displayed "increased behaviors" in March of 2015 and leading up to the resident's 4/3/15 Zyprexa medication dose increase. She indicated the behaviors were "poking staff with his finger" and slapping a CNA on the arm. She indicated she did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>document those behaviors on the facility's behavior logs or record them in progress notes because the concerns were verbally communicated to the resident's Hospice nurse and the resident's physician through interdisciplinary team meetings. She also indicated normally behaviors described above would be documented by staff in nursing progress notes and on facility behavior logs.</p> <p>A facility policy titled "Charting and Documentation", dated April 2008, indicated "...All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record..." and "...All observations, medications administered, services performed, etc., must be documented in the resident's clinical records..." and "...All incidents, accidents, or changes in the resident's condition must be recorded..."</p> <p>A behavior care plan, updated 3/31/15, indicated "...If behavioral symptoms are observed, record and document on a "Behavioral Tracking Form"..."</p> <p>"Behavior Monitoring Record" for Resident #5, dated for the months of September, October, November, and December of 2014 and January, February,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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
F 999  Bldg. 00	and March of 2015 indicated the resident did not have behavioral symptoms.  3.1-50(a)(2)  3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.	F 999		06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff received annual in-service education on residents rights for 2 of 10 staff members reviewed for residents' rights in-service education. (LPN #4 and Laundry Staff #5)</p> <p>Findings include:</p> <p>The Employee Records form and 10 employee personnel files were reviewed on 4/29/15 at 2:00 p.m. The Employee Records form indicated a start date of 12/12/12 for LPN #4 and start date of 1/25/08 for Laundry Staff #5. The employee personnel files for LPN #4 and Laundry Staff #5 did not include verification of annual training for either employee on residents' rights.</p> <p>On 4/30/15 at 12:34 p.m., the ADON (Assistant Director of Nursing) provided verification the last residents' rights training for Laundry Staff #5 was 6/2/13. He indicated he did not know the last time LPN #4 received training on residents' rights, and could not provide verification of the last training.</p> <p>On 4/30/15, at 12:30 p.m., the Housekeeping Supervisor provided a list</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
--	--

(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>of days worked by LPN #4 in March and April, 2015 and a list of days worked by Laundry Staff #5 in March and April, 2015. LPN #4's list indicated she worked 17 days. Laundry Staff #5's list indicated she worked 36 days.</p> <p>The In-Service Training Program policy was provided by the Housekeeping Supervisor on 4/30/15 at 12:30 p.m. It indicated, "1. All personnel are required to attend regularly scheduled in-service training (Staff Development) classes....6. All training classes attended by the employee shall be entered on the respective employee's Employee Training Attendance Record by the Department Director or other person(s) designated by that director. 7. Records shall be filed in the employee's personnel file or shall be maintained by the Department Director. 8. The following in-service training (Staff Development) classes are mandatory (i.e., each employee must attend a training class on each of the following topics): ...e. Resident Rights."</p>			