

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00200463.</p> <p>Complaint IN00200463 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: May 31, June 1, 2 3, 6, 7, and 8, 2016.</p> <p>Facility number: 000248 Provider number: 155357 AIM number: 100291470</p> <p>Census bed type: SNF/NF: 98 Residential: 53 Total: 151</p> <p>Census payor type: Medicare: 20 Medicaid: 64 Other: 67 Total: 151</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F 0000	<p>This plan of correction does not constitute an admission by Rawlins House or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility Nor does this submission constitute an agreement or admission of an agreement or a admission of the survey allegations</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: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 0279 SS=E Bldg. 00	<p>QR completed on June 10, 2016 by 17934.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans with measurable goals and objectives regarding psychoactive medication use, for 5 of 5 residents who met the criteria for unnecessary medication (Residents #1, #169, #68, #91 and #125).</p>	F 0279	<p>I Resident #1,#68,#91,#125 and #169 have had their care plans modified to show targeted behaviors and measurable goals</p> <p>II All resident receiving psychoactive medications have the potential to be affected All</p>	06/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064		
(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. Resident #1's clinical record was reviewed on 6/6/16 at 2:09 p.m. Resident #1's diagnoses included, but were not limited to, chronic pain, major depressive disorder, dementia without behaviors, generalized anxiety disorder and blindness in both eyes.</p> <p>Resident #1 had a current, 3/24/16, physician's order for Ativan 0.5 mg (an anti-anxiety medication) give 1 tablet as need three times daily as needed for generalized anxiety disorder.</p> <p>Resident #1 also had a current, 3/13/14, physician's order for citalopram 10 mg (an anti-depressant medication) take 1 tablet daily for major depressive disorder.</p> <p>Resident #1 had a, current, 5/5/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had highly impaired vision and hearing, and rarely or never understood communication.</p> <p>Resident #1 had a current, 5/16/16, care plan problem/need regarding requiring the use of an anti-anxiety medication for the treatment of anxiety as evidenced by continuous yelling, hallucinations,</p>		<p>residents receiving psychoactive meds have had their care plans reviewed and modified to show targeted behaviors and measurable goals</p> <p>III The systematic change is that the facility will review residents with new psychoactive medications for placement of a care plan that included targeted behaviors and measurable goals daily during clinical stand up meeting (Monday through Friday) Education will be provided to all licensed staff regarding comprehensive care planning when residents have psychoactive medications</p> <p>IV The DON or designee will audit residents with new psychoactive medications for targeted behaviors and measurable goals in the care plan 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 80 days to total 12 months Results of report findings will be reported to the QA committee monthly for 12 months After 100% compliance is reached the QA committee will determine the frequency of continued monitoring Completion Date: June 28,2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>delusions, tearfulness and inconsolable crying. This care plan problem/need originated 12/5/14. A goal for this problem was "Resident will have effective management of targeted behaviors."</p> <p>Resident #1 had a current, 5/16/16, care plan problem/need regarding requiring the use of an anti-depressant medication to treat major depression as evidenced by tearfulness, hallucinations, inconsolable crying, periods of disturbed sleep pattern, refusing medications, poor appetite, refusing to eat and periods of excessive restlessness. This problem/need originated 12/5/14. A goal for this problem was "Resident will have effective management of targeted behaviors."</p> <p>2. Resident #169's clinical record was reviewed on 6/6/16 at 8:47 a.m. Resident #169's diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and insomnia.</p> <p>Resident #169 had a current, 5/20/16, physician's order for trazadone 50 mg (an anti-depressant medication often used to treat insomnia) 1 tablet daily at bedtime for insomnia.</p> <p>Resident #169 had a current, 5/20/16,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>physician's order for Zyprexa 10 mg (an anti-psychotic medication sometimes used to treat recurrent major depression) 1 tablet daily for recurrent major depression.</p> <p>Resident #169 had a current, 5/21/16, physician's order for Paxil 30 mg (an anti-depressant medication) 1 tablet daily for major depressive disorder.</p> <p>Resident #169, had a current, 6/1/16, care plan problem/need regarding the need for an anti-depressant medication to treat depression as evidenced by depressed mood. This care plan problem/need originated 5/23/16. A goal for this problem was "Resident will have effective management of targeted behaviors."</p> <p>Resident #169 had a current, 6/1/16, care plan problem/need a need for a hypnotic medication to treat insomnia as evidenced by disturbed sleep. This care plan problem/need originated 5/23/16. A goal for this problem was "Resident will have effective management of targeted behaviors."</p> <p>Resident #169 had a current, 6/1/16, care plan problem/need the need for an anti-psychotic medication to treat a mood disorder. This care plan problem/need</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>originated 5/23/16. A goal for this problem was "Resident will have effective management of targeted behaviors."</p> <p>3. The clinic record for Resident #68 was reviewed on 6/2/16 at 9:56 a.m. Diagnoses for Resident #68 included, but were not limited to, depression, diabetes, and fracture of the lower left leg.</p> <p>Resident #68 had a current physician's order for duloxetine (an anti-depressant medication) 30 mg, 1 capsule by mouth once a day. The original date of this order was 3/18/16.</p> <p>Resident #68 had a 3/25/16, admission Minimum Data Set (MDS) assessment which indicated the resident was cognitively intact.</p> <p>Resident #68 had a current, 3/21/16, health care plan for depression which required the use of an anti-depressant medication "AEB [As Evidenced By] depresses mood. The goal of the health care plan was "Resident will have effective management of targeted behaviors."4. The record of Resident #91 was reviewed on 6/6/2016 at 10:37 a.m. Resident #91 had current diagnoses which included, but were not limited to, dementia without behavioral disturbances, abnormalities of gait and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>mobility, abnormal posture, muscle weakness, hereditary and idiopathic neuropathy, depression, and chronic pain.</p> <p>Resident #91 had a current, 6/07/2016, physician's order for Namenda 5 mg once a day (an Alzheimer's medication), Neurontin 100 mg. at bedtime (a nerve pain medication) Zoloft 25 mg at bedtime (a depression medication).</p> <p>Resident # 91 had a, 5/17/2016, quarterly, Minimum Data Set (MDS) assessment which indicated Resident #91 has severe COGNITIVE impairments, never/rarely made decisions, AND had no behaviors noted. Resident #91's functional abilities were supervision with bed mobility, transfers, locomotion on/off the unit, eating, toilet use. Resident #19 required extensive assistance with personal hygiene, and limited assistance with dressing.</p> <p>Resident #91 had a current, 5/24/2016, care plan problem/need regarding a depression diagnosis that required the use of antidepressant medication as evident by, refusing treatment and depressed mood. This care plan problem/need originated 12/22/2015. The goal for this problem/need was resident will have effective management of targeted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>behaviors. This goal had no timetables and objectives in measurable outcomes. Resident #91 had a, 5/04/2016, "progress note", which indicated Resident #91 received a new order for the reduction of Zoloft related to no signs or symptoms of increased depression.</p> <p>5. The record of Resident #125 was reviewed on 06/07/2016 8:37 a.m. Resident #125 had current diagnoses which included, but were not limited, psychotic disorder with delusions, major depressive disorder, cognitive communication deficit, chronic pain, and anxiety.</p> <p>Resident #125 had a current, 6/07/2016, physician's order for chlorpromazine 10 mg three times a day, chlorpromazine 25 mg at bedtime (an antipsychotic medication), and citalopram 10 mg (a depression medication).</p> <p>Resident #125 had a, 3/01/2016, 14 day Minimum Data Set (MDS) assessment which indicated Resident #125 had severe impairments and never/rarely made decisions. Resident #125 had noted physical behaviors for 1 to 3 days during the assessment and had other behavioral symptoms not directed toward others for 1 to 3 days. Resident #125 had rejection of care noted 1 to 3 days during</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 MDS assessment.</p> <p>Resident #125 had a current, 6/24/2016, care plan problem/need regarding a diagnosis of psychotic disorder with delusions that required the use of antipsychotic medication(s) as evidenced by agitation, verbal aggression, physical aggression, wandering, and being resistive to or refusing care. Resident with delusions that the doll she carries is a real baby. This care plan problem/need originated 04/19/2016. The goal for this problem/need was resident will have effective management of targeted behaviors. This goal had no timetables and objectives in measurable outcomes.</p> <p>Resident #125 had a, 3/1/2016 - 3/31/2016, "BEHAVIOR MANAGEMENT ADMINISTRATION HISTORT REPORT", which indicated Resident #125 had 5+ behaviors noted for verbal aggression, physical aggression and delusions.</p> <p>Resident #125 had a, 4/1/2016 - 4/30/2016, "BEHAVIOR MANAGEMENT ADMINISTRATION HISTORT REPORT", which indicated Resident #125 had 6 behaviors noted for verbal aggression, physical aggression, exit seeking and refusing of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 #125 had a, 5/1/2016 - 5/31/2016, "BEHAVIOR MANAGEMENT ADMINISTRATION HISTORT REPORT", which indicated Resident #125 had 6 behaviors noted for verbal aggression, refusing of care and inconsolable crying.</p> <p>During a 6/8/16, 9:15 a.m., interview, Social Services Designee #1 indicated the facility did not have a method to measure the effectiveness of the "management of targeted behaviors." She indicated she had been unaware of the need for care plans to have measurable goals and objectives. She indicated she had use the care plan template that was available and had not personalized it for each resident.</p> <p>During an interview on 6/7/16 at 9:47 a.m., Nurse Consultant #24 indicated health care plans needed to have measurable goals. She further indicated "effective management of targeted behaviors," was not a measurable goal.</p> <p>A current, 10/2010 facility policy, titled "CARE PLANS-COMPREHENSIVE", provided by RN consultant #24 on 6/7/2016 at 9:50 a.m., indicated: "an individualized comprehensive care plan that includes measurable and timetables to meet the resident's medical, nursing,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 0282 SS=D Bldg. 00	<p>mental and psychological needs is developed for each resident....each resident's comprehensive care plan is designed to...reflect treatment goals, timetables and objectives in measurable outcomes."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's orders related to taking temperatures for 1 of 25 residents reviewed for physician's orders. (Resident #102)</p> <p>Findings include:</p> <p>The record of Resident #102 was reviewed on 6/3/2016 8:40 a.m. Resident #102 had current diagnoses which included, but were not limited to, lung cancer, history of urinary tract infection and squamous cell carcinoma of the ear</p>	F 0282	<p>I Resident #102 no longer has a physician's order for reporting a temperature of 1005 or higher</p> <p>II All residents having an order to report an elevated temperature have the potential to be affected A 100% audit of all in house residents has been completed There are no other in house residents with an order to report an elevated temperature</p> <p>III The systematic change includes that all residents with new orders to report an elevated temperature</p>	06/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064			
(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>canal.</p> <p>Resident #102 had a current physician's order that indicated "If temperature of 100.5 or higher please call [physician name] right away, day or night at the office or through the answering service. Twice a day; 6:00 AM- 2:00 PM, 2:00 PM - 10:00 PM." This order originated on 1/27/2016.</p> <p>Resident #102 had a current, 5/25/2016, care plan problem regarding "Resident at risk for complications r/t [related to] radiation treatments." The goal for this problem was "Resident will not exhibit adverse effects of radiation Tx [treatment]" Approaches to this problem included, but were not limited to, "Monitor for s/sx [signs/ symptoms] of adverse effects of radiation...fever...." During an interview with Clinical Nurse Specialist #20 on 6/3/2016 at 11:37 a.m., she indicated she felt this order was just an "FYI"(for your information) for nursing staff and the temperature for Resident #102 did not actually need to be measured each day two times per day. She then indicated the nursing staff had not taken the temperature of Resident #102 everyday, they only took his</p>		<p>to the physician will be reviewed in the clinical stand up meeting (Monday through Friday) by the DON or designee to determine if the temperature was taken and if elevated above the ordered parameter it was reported Education will be provided to licensed nurses to include following physician orders for reporting elevated temperatures IV DON/Designee will audit through review of MAR's(Medication Administration Records) This review will be done for 100% of MAR's for residents that have an order to monitor elevated temperatures 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months Results of report findings will be reported to the QA committee monthly for 12 months After 100% compliance is reached the QA committee will determine the frequency of continued monitoring Completion Date: June 28, 2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064		
(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>temperature when he was on antibiotic.</p> <p>She indicated that even though it was initialed on the TAR [treatment administration record] as being completed, the temperature was not being measured.</p> <p>During an interview with LPN #21 on 6/7/2016 9:36 a.m., she indicated she was not the nursing staff on the hallway for Resident #102, she knew the nursing staff was taking the temperature of Resident #102 two times per day according to the order because he was getting radiation due to having cancer. LPN #21 indicated the temperatures would be charted in the "MAR" [medication administration record].</p> <p>During an interview with Nurse Consultant #24 on 6/7/2016 at 3:15 p.m., she indicated the facility did not have a policy for following physician orders. She further indicated the nursing staff should be following all physician orders.</p> <p>The "Medication Administration History" for Resident #102, was provided by Clinical Nurse Specialist #20 on 6/3/2016 at 11:30 a.m., indicated the following:</p> <p>1/2/2016 through 1/31/2016, Resident #102's temperature was measured on 9 of 60 shifts while taking cefuroxime</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>(antibiotic).</p> <p>2/1/2016 through 2/29/2016, Resident #102's temperature was measured two of 58 shifts while taking cefuroxime (antibiotic).</p> <p>5/25/2016 through 5/28/2016, Resident #102's temperature was measured four times while taking azithromycin (antibiotic).</p> <p>The "Treatment Administration History" for Resident #102, was provided by Clinical Nurse Specialist #20 on 6/3/2016 at 11:30 a.m., indicated the following:</p> <p>Resident #102's temperature was measured 3/14/2016 through 3/16/2016 following an event. No temperature was recorded for 56 of 56 other shifts.</p> <p>Resident #102's temperature was measured 4/6/2016 through 4/8/2016 following an event. No temperature was recorded for 54 of 54 other shifts.</p> <p>The "Treatment Administration History" for 1/1/2016 through 5/31/2016, for Resident #102 was provided by Clinical Nurse Specialist #20 on 6/3/2016 at 12:30 p.m., indicated the order for temperatures for Resident #102 to be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 0329 SS=D Bldg. 00	<p>taken twice daily. There was not an area to provide a temperature value.</p> <p>No other documentation was provided indicating temperature values for Resident #102 prior to exit.</p> <p>3.1-35(g)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review the facility failed to ensure</p>	F 0329	<p>1</p> <p>Resident #1 was assessed and</p>	06/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064			
(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>behavioral events were fully documented, non-chemical interventions were attempted, and a thorough physical assessment was completed prior to the administration of an as needed anti-anxiety medication for 1 of 1 resident who received as needed anti-anxiety medication in a sample of 5 residents who met the criteria for unnecessary medications (Resident #1).</p> <p>Findings include:</p> <p>Resident #1's clinical record was reviewed on 6/6/16 at 2:09 p.m. Resident #1's diagnoses included, but were not limited to, chronic pain, major depressive disorder, dementia without behaviors, generalized anxiety disorder and blindness in both eyes.</p> <p>Resident #1 had a current, 3/24/16, physician's order for: Ativan 0.5 mg (an anti-anxiety medication) give 1 tablet three times daily as needed for generalized anxiety disorder.</p> <p>Resident #1 had a current, 3/24/16, physician's order for: acetaminophen 325 mg (a pain reliever) give 2 tablets (650 mg) every 6 hours as needed for pain.</p> <p>Resident #1 had a, current, 5/5/16, quarterly, Minimum Data Set (MDS)</p>		<p>use of non pharmaceutical approaches are in place per the resident's care plan</p> <p>II Residents who are receiving as needed anti anxiety medications have the potential to be affected Residents receiving as needed anti-anxiety medications in the past 30 days were reviewed for non pharmaceutical interventions The physician was notified of residents receiving anti anxiety medications in the past 30 days without non pharmaceutical interventions</p> <p>III The systematic change is to review any residents that received PRN anti anxiety medication daily in the clinical stand up meeting Monday through Friday to determine that non drug interventions were attempted and that nurses will document in the MAR in the non drug intervention Licensed nurses were provided education on appropriate medical symptoms and or diagnosis to warrant the use of an anti-anxiety medication, behavior monitoring, documentation and non pharmaceutical interventions before administering PRN anti-anxiety medications</p> <p>IV The DON/Designee will review 24 hour reports and medication administration records for any PRN anti- anxiety medication administration 5 times per week for 30 days, then 5 times per</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064			
(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>assessment which indicated the resident had highly impaired vision and hearing, and rarely or never understood communication.</p> <p>Resident #1 had a current, 5/16/16, care plan problem/need regarding anxiety and the use of anti-anxiety medication. This care plan problem/need originated 12/5/14. A goal for this problem was "The resident will use the lowest does of this medication while maintaining the highest level of psychosocial functioning." Approaches to this problem included, but were not limited to, monitoring behaviors and providing non-chemical interventions.</p> <p>Resident #1 had a current, 5/16/16, care plan problem/need regarding chronic pain. This care plan problem/need originated 2/13/16. The goal for this problem was for the resident to have a consistent level of comfort.</p> <p>Review of Resident #1's as needed Medication Administration record for 3/24/16 to 6/6/16 (76 day period) indicated the following:</p> <p>a. Resident #1 received no as needed acetaminophen during this 76 day period.</p> <p>b. Resident #1 received as needed Ativan 4 times: 4/4/16 at 4:25 p.m.,for yelling</p>		<p>month for 150 days, then 3 times per month for 180 days to total 12 months</p> <p>Results of report findings will be reported to the QA committee monthly for 12 months After 100% compliance is reached the QA committee will determine the frequency of continued monitoring Completion Date: June 28, 2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>continuously, 4/11/16 at 6:45 p.m., for yelling out, 5/10/16 at 4:20 p.m., for yelling to cross the street, 5/15/16 at 7:09 a.m., for yelling.</p> <p>Three of the four behavioral events which required as needed anti-anxiety medication (5/15/16, 4/11/16 and 4/4/16) had only the yelling documented on the Medication Record as the reason to administer the medication. Resident #1's clinical record lacked:</p> <ol style="list-style-type: none"> An in depth description of the behavioral event which would allow for the assessment of possible contributing factors, A physical assessment for possible physical contributors to yelling including an assessment for possible pain, Documented non-chemical interventions attempted prior to the use of the as needed anti-anxiety medication. <p>Resident #1 was observed during the following dates and times. She often displayed signs of dementia without any sign of distress as follows: On 6/3/16 at 10:41 a.m., she was quietly resting in her bed. On 6/3/16 at 11:34 a.m., she was seated in the lounge. She was calmly making statements that another resident was her brother.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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 6/3/16 at 11:37 a.m., she was singing with the staff on her way to the dining room.</p> <p>On 6/6/16 at 9:04 a.m., she was in bed in her room calmly talking to the empty room.</p> <p>On 6/6/16 at 1:38 p.m., she was resting in her bed.</p> <p>During a 6/8/16, 9:58 a.m., interview, RN Consultant #24 indicated the facility did not have supporting documentation, documented interventions or documented physical assessments for the use of the as needed anti-anxiety medication on 5/15/16, 4/11/16 and 4/4/16. She additionally indicated this documentation should have been completed.</p> <p>A, current, October 2013, facility policy titled "Behavior Management Program", provided by the Administrator on 6/8/16 at 2:00 p.m., indicated the following: "It is [corporation name]'s policy to ensure that the etiology of a residents behavior is thoroughly invested, documented and care planned to rule out underlying causative factors that may exist outside of a medical diagnosis."</p> <p>3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064			
(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 0514 SS=D Bldg. 00	<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 a resident's clinical record was complete and accurate regarding behaviors before placement of a wander guard for 1 of 2 residents reviewed for wander guard placement. (Resident #59)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #59 was reviewed on 6/7/16 at 8:32 a.m. Diagnoses for Resident #59 included, but were not limited to, dementia, physical debility, and depression.</p> <p>Resident #59 had a physician's order to check placement and function of the wander guard to the left lower extremity every shift. This order originated 3/25/16</p>	F 0514	<p>I Resident # 5 no longer resides in the facility</p> <p>II All residents with a wander guard have the potential to be affected Residents with wander guard were assessed to determine if the device was indicated Any issues identified were corrected</p> <p>III The systemic changes included that licensed nurses will be educated on complete and accurate documentation prior to application of a wander guard Any resident with a new application of a wander guard will be reviewed Monday through Friday at the daily clinical stand up meeting to determine complete and accurate documentation is in the medical record Any issues identified will</p>	06/28/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>and was discontinued 5/17/16.</p> <p>Resident #59 was admitted on 3/22/16. An "Admission--Elopement Risk Assessment" was completed on 3/22/16. The assessment indicated the resident did not wander aimlessly, did not exit seek or stand next to an exit door often, did not have a history of elopement, was not making statements about missing family/things outside of the facility or plans to leave the facility.</p> <p>An "Admission--Elopement Risk Assessment" for Resident #59 dated 3/25/16 at 2:25 p.m., indicated the resident did wander aimlessly and exit seek or stand next to an exit door often.</p> <p>Review of the nurses notes from 3/22/16 to 3/25/16 lacked any documentation regarding Resident #59 wandering or exit seeking. A nurses note dated 3/26/16 at 3:29 a.m., indicated the resident had "...a few episodes of wandering about the unit and being redirected to room, wander guard on LLE and functioning...."</p> <p>The nurses notes and the 3/25/16 elopement risk assessment for Resident #59 lacked any details or description of the wandering and/or exit seeking behaviors. Information including, but not limited to, where the resident wandered</p>		<p>be corrected IV The DON/Designee will review documentation for wander guard application for wander guard application and documentation 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months Results of report findings will be reported to the QA committee monthly for 12 months After 100% compliance is reached the QA committee will determine the frequency of continue monitoring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

(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>(secure or non-secured area), how often the resident wandered, what type of exit seeking behavior resident displayed, any interventions attempted and results of interventions.</p> <p>Review of the March 2016 "Behavior Management Administration History" indicated to monitor Resident #59's behavior of "wandering" every shift. The start date on the history was 3/31/16.</p> <p>During an interview on 6/7/16 at 2:11 p.m., Nurse Consultant #24 indicated the "Admission--Elopement Risk Assessment" dated 3/25/16, for Resident #59 was the behavior documentation for the wander guard. She further indicated the documentation regarding the behaviors for the wander guard was lacking in description and details.</p> <p>Review of the current, 12/1/14, policy, titled "Elopement Risk Policy", provided by Nurse Consultant #24 on 6/7/16 at 3:16 p.m., included, but was not limited to,</p> <p>"...This policy serves as guidance to the [corporation name] on identifying and initiating a plan of care for residents with history of elopements and/or risk of elopement....</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
---	---

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

R 0000 Bldg. 00	<p>...Residents will be identified for elopement risk by the following: Nursing assessment upon admission New or worsening behavior event of wandering, exit seeking, or elopements after admission to the community</p> <p>Upon either assessment or event outlined above, the resident is determined to be at risk for elopement if they are cognitively impaired and have one or more of the following risk behaviors: Wanders aimlessly in a non-secured area Exit seeking Expresses the need to go home, leave, search for something or someone in a non-secured area Expresses anger/agitation about being placed in the community, [dropped off left or abandoned.] History of elopements from home or another facility..."</p> <p>3.1-50(a)(1)</p> <p>This visit was for a State Residential</p>	R 0000	This plan of correction does not constitute an admission by	
------------------------	--	--------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064		
(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	
	Licensure Survey. Residential Census: 53 Sample: 7 Rawlins House Health & Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.		Rawlins House or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility Nor does this submission constitute an agreement or admission of an agreement or a admission of the survey allegations		