

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2013
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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00123409.</p> <p>Complaint IN00123409-Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Dates of Survey: February 24-28, 2013</p> <p>Facility number: 000388 Provider number: 15E244 AIM number: 100454140</p> <p>Survey team: Beth Walsh, RN-TC Karina Gates, BHS Courtney Mujic, RN Gloria Bond, RN</p> <p>Census bed type: NF: 39 Total: 39</p> <p>Census payor type: Medicaid: 39 Total: 39</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>This plan of correction is to serve as Rural Health Care Centers' credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Rural Health Care Center or its' management company that the allegations contained in the survey report are 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 the survey allegations.</p> <p>Rural Health Care Center respectfully requests paper review. Our date of compliance is 03/22/2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	IAC 16.2. Quality review 3/07/13 by Suzanne Williams, RN				

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview, the facility failed to notify the physician when an ordered medication was not given for 1 of 10 residents reviewed for unnecessary</p>	F000157	<p>F157 483.10(b)(11) NOTIFICATION OF CHANGES It is the practice of Rural Health Care Center to : (i) immediately inform the resident; consult with the resident's physician; and if</p>	03/22/2013			

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	<p>medications. Resident #36.</p> <p>Findings include:</p> <p>Resident #36's clinical record was reviewed on 2/26/2013 at 10 a.m. The resident's diagnoses included, but were not limited to; chronic schizophrenia paranoid, generalized anxiety disorders, diabetes, chronic obstructive pulmonary disease, cardiac dysrhythmia, dementia.</p> <p>A review of the physician orders recapitulation for February 2013 indicated, "Lithium Carbonate 150mg cap 1 capsule by mouth twice daily with 300mg cap to = 450mg."</p> <p>A "Behavior Monitoring record" dated 2/9/13 at 4:30 am indicated, "cursing and talking about hitting."</p> <p>Resident #36's medication administration record (MAR) indicated, by the circle around the nurse's initials and notation on the back of the MAR, that he did not receive his Lithium 150mg on 2/9/2013, 2/10/2013, and 2/11/2013 as ordered, because the medicine was not available according to what was written on the back of the MAR. On 2/11/2013 a written explanation on the back of the MAR indicated that</p>		<p>known, notify the resident's legal representative or interested family member when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment significantly; or (D) A decision to transfer or discharge the resident from the facility. (ii) The facility also notifies the resident or responsible party of-</p> <p>(A) A change in the room or roommate assignment (B) A change in resident's rights (iii) The facility records and periodically updates the address and phone number of the resident's legal representative or interested family member. I. Resident #36's physician has been notified of the missed doses of Lithium Carbonate. II. All other residents have the potential to be affected. III. The facility's policy regarding physician notification has been reviewed and found to be complete. Licensed nurses have been re-educated on this policy including the need to notify the physician when there is missed doses or refusal of a medication or treatment for two or more consecutive doses. IV. The DON or her designee is conducting quality improvement audits of physician notification. This audit includes checking medication and treatment records</p>				

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	<p>Lithium carb 150mg was "not in."</p> <p>An interview, on 2/27/2013 at 3:30 pm, with RN #5, confirmed that the circle around the initials on the medication administration record (MAR) indicated that the medication was not given and the reason was written on the back of the MAR.</p> <p>An interview, on 2/28/2013 at 9:30 am, with the D.O.N. indicated, that in regard to the Lithium for Resident #36, the physician had not been notified of the missed doses but the doctor was going to be contacted and informed today.</p> <p>3.1-5(a)(3)</p>		<p>for any refused or unavailable doses and proper physician notification. A random sample of 5% of residents is being audited weekly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary.</p>		

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 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 record review and interview, the facility failed to revise a care plan following a fall for 1 of 23 residents whose care plans were reviewed. Resident #15.</p> <p>Findings included:</p> <p>Resident #15's clinical record was reviewed on 2/27/2013 at 1:45 pm. Diagnoses included, but were not limited to; depressive disorder, hypertension, a history of seizures, encephalopathic anoxia (brain deprived of oxygen), anxiety, and a history of cardiac arrest.</p>	F000280	<p>F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN</p> <p>It is the practice of Rural Health Care Center to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the</p>	03/22/2013			

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	<p>A quarterly MDS (minimum data set) assessment, dated 12/9/2012, indicated, BIMS (brief interview for mental status) score of 9 out of a total of 15. This score indicated the resident was cognitively impaired.</p> <p>A "Quarterly nursing assessment" dated 1/11/2013, indicated, "Fall risk total score: 10, high risk."</p> <p>A "Incident/accident report and investigation" dated 2/20/2013 at 7:10 am, indicated, "Describe exactly what happened: Patient got up from bed and slip out to her knees. [sic] Denies pain. Ambulated without difficulty. Actions taken to prevent recurrence: Res. (resident) told not to jump straight out of bed but to sit at side 1st to get her footing. Very dementia-not expected to do. [sic] Nurse investigation of incident: 2. What did resident say happened? Slip out bed trying to get up. Root cause identified: slipped off bed, not prone to falls."</p> <p>An "Interdisciplinary team progress note", dated 2/21/2013 with no time specified, indicated, "Resident was reviewed in IDT (Interdisciplinary team meeting) due to fall on 2/20/2013. She got out of bed and slipped to her knees. Fall appeared to</p>		<p>participation of the resident, the resident's family or legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>I. Resident #15's care plan has been updated to include fall prevention strategies.</p> <p>II. The facility realizes other residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The facility's policy on care planning has been reviewed and found to be complete. Licensed nurses and the interdisciplinary team have been re-educated on this policy. In addition, any resident who has a fall will be reviewed during the facility's daily IDT meeting. The care plan will be updated at this time.</p> <p>IV. The DON or her designee is conducting quality improvement audits. This audit includes checking care plans to ensure that resident problems, including falls, have been addressed and have current interventions listed.</p>				

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	<p>be an isolated event. She was told to sit on the side of the bed for a few seconds when she gets up and not to jump straight up out of bed. She said OK but is very demented and not expected to remember. MD was notified. She is her own responsible party. She sustained no injuries. No further interventions appear warranted at this time."</p> <p>An interview with the D.O.N. and the A.D.O.N., on 2/27/2013 at 2:40 pm indicated the resident is, "able to verbally tell staff what happens in circumstances surrounding a fall. She is able to say whether or not she hit her head. However, she has very short term memory and is unable to recall why she is here almost daily. Her medication patch is put on her in the morning, and sometimes a couple hours later she can't remember it was placed on her arm."</p> <p>A care plan, dated 11/29/2012, indicated, "Focus: The resident has potential for falls related to psychoactive drug use, incontinence, and history of seizure disorder. Goals: The resident will be free of falls through the next review of 90 days." The most recent date the intervention section was updated was 11/29/2012.</p>		<p>This will include a review of the CNA assignment sheet to ensure all caregivers are aware of the prevention techniques. A random sample of 5% of residents is being audited weekly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary.</p>				

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	<p>An interview with the D.O.N., on 2/28/2013 at 1 pm, indicated it was an oversight that the intervention they came up with in the IDT following the fall on 2/20/2013 wasn't on the care plan, and it should have been.</p> <p>A policy titled, "Resident falls, other accidents, and unusual occurrences," provided by the Administrator, on 2/28/2013 at 11:20 am indicated, "Suggested guidelines for review: 2. Care plan and implement preventive measures for the resident at risk for falls and behaviors."</p> <p>3.1-35(b)(2)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow physician's orders for TED (compression) hose and medication for 3 of 11 residents reviewed for physician's orders (Resident #11, #19, and #36).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 2/27/13 at 10:00 a.m. The diagnoses for Resident #11 included, but were not limited to: edema and right hemiplegia.</p> <p>A recapitulation of the February Physician's Orders indicated Resident #11 was to have T.E.D (compression) knee-hi hose on in the morning and off in the evening, daily.</p> <p>During an interview with the DoN (Director of Nursing), on 2/27/13 at 11:55 a.m., she indicated her expectation was for staff to follow physician's orders as ordered.</p>	F000282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</p> <p>It is the practice of Rural Health Care Center to provide services by qualified persons in accordance with each resident's written plan of care.</p> <p>I. Resident #11 and Resident #19 refuse to wear TED hose. The physician was notified and these orders were discontinued. Resident #36 is receiving the medication as ordered.</p> <p>II. Residents with orders for TED hose were reviewed to ensure Resident has TED hose and is wearing them. Residents receiving medications have the potential to be affected by medications unavailable.</p> <p>III. Licensed nurses have been</p>	03/22/2013			

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	<p>During the following random observations, Resident #11 was not wearing T.E.D hose: 2/27/13 at 10:47 a.m., 2/28/13 at 10:25 a.m., 2/28/13 at 11:15 a.m.</p> <p>At 11:15 a.m., on 2/28/13, the DoN (Director of Nursing) indicated, during an observation of Resident #11, the T.E.D hose were not located within the Resident's belongings and the facility would get the Resident a new pair of T.E.D hose. She also indicated the Resident probably threw the hose away and probably hadn't been wearing the T.E.D hose for a week.</p> <p>2. The clinical record for Resident #19 was reviewed on 2/27/13 at 2:00 p.m. The diagnoses for Resident #19 included, but were not limited to: cerebral vascular disease, bilateral lower extremity edema, and hypertension.</p> <p>A recapitulation of the February Physician's Orders indicated Resident #19 was to have T.E.D (compression) hose on in the morning and to remove them at bedtime, daily.</p> <p>During the following random observations, Resident #19 did not</p>		<p>re-educated regarding the importance of following physician's orders and the written care plan. The policy for reordering medications has been reviewed and updated to include calling the pharmacy directly if any medication is unavailable. Licensed nurses were educated on this policy.</p> <p>IV. The DON or her designee is conducting quality improvement audits. This audit includes checking 100% of the residents who wear TED hose to make sure they are on as ordered. This audit also includes checking medication and treatment records for any unavailable doses; and then the prompt re-ordering of the medication and physician notification where appropriate. A random sample of 5% of residents is being audited weekly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary.</p>		

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	<p>have on T.E.D hose: 2/28/13 at 11:00 a.m. and 2/28/13 at 11:40 a.m.</p> <p>During an interview with Resident #19, on 2/28/13 at 11:00 a.m., she indicated her T.E.D hose been missing for a month, so she had not been wearing them, since they went missing.</p> <p>A review of the Quarterly MDS (Minimum Data Set), dated 11/24/12, indicated Resident #19 had a BIMS of 15, which was indicative of no cognitive impairment.</p> <p>At 11:41 a.m., on 2/28/13, the DoN (Director of Nursing) indicated she talked to Resident #19 about the missing TED hose. She also indicated the facility will get the resident a new pair of TED hose and she was not sure of how long the Resident was not wearing T.E.D hose, but it was probably a week.</p> <p>3. Resident #36's clinical record was reviewed on 2/26/2013 at 10 a.m. The resident's diagnoses included, but were not limited to; chronic schizophrenia paranoid, generalized anxiety disorders, diabetes, chronic obstructive pulmonary disease, cardiac dysrhythmia, dementia.</p>						

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	<p>A review of the physician orders recapitulation for February 2013 indicated, "Lithium Carbonate 150mg cap 1 capsule by mouth twice daily with 300mg cap to = 450mg."</p> <p>A "Behavior Monitoring record" dated 2/9/13 at 4:30 am indicated, "cursing and talking about hitting."</p> <p>Resident #36's medication administration record (MAR) indicated, by the circle around the nurse's initials and notation on the back of the MAR, that he did not receive his Lithium 150mg on 2/9/2013, 2/10/2013, and 2/11/2013 as ordered, because the medicine was not available according to what was written on the back of the MAR. On 2/11/2013 a written explanation on the back of the MAR indicated that Lithium carb 150mg was "not in."</p> <p>An interview, on 2/27/2013 at 3:30 pm, with RN #5, confirmed that the circle around the initials on the medication administration record (MAR) indicated that the medication was not given and the reason was written on the back of the MAR.</p> <p>An interview, on 2/28/2013 at 9:30 am, with the D.O.N. indicated, that in regard to the Lithium for Resident</p>						

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	<p>#36, it was something she is checking into and this was just brought to her attention yesterday. The D.O.N. indicated, that she is not sure what exactly happened with the reordering of the Lithium for resident #36 and is not sure if it was a problem on the facility's end or on the pharmacy's end that something went wrong. The D.O.N. also indicated that the Physician had not been notified of the missed doses but the doctor was going to be contacted and informed today.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the front exit door was locked resulting in an elopement for 1 of 1 resident reviewed for elopement. (Resident #49)</p> <p>Findings include:</p> <p>The clinical record for Resident #49 was reviewed on 2/27/13 at 11:00 a.m. Resident #49 was admitted to the facility on 1/24/13 from another ECF (Extended Care Facility).</p> <p>The diagnoses for Resident #49 included, but were not limited to: schizoaffective disorder.</p> <p>The 1/24/13 Interdisciplinary Discharge Summary from Resident #49's previous ECF was found in Resident #49's clinical record and indicated, "Reason for discharge/discharge diagnosis(es): Elopement."</p> <p>The 1/24/13 Hospital/Acute Care</p>	F000323	<p>F323 483.25(h) ACCIDENTS</p> <p>It is the practice of Rural Health Care Center to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. Resident #49 no longer resides in the facility.</p> <p>II. All residents have the potential be affected by the security of the exit door. The door has been checked and does close securely.</p> <p>III. Facility personnel were educated at the time of the incident and have been re-educated regarding making sure that any exit door is securely closed when entering and exiting</p>	03/22/2013			

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	<p>Transfer form from Resident #49's previous ECF indicated, "Reason for Transfer/Summary: facility unable to meet res (resident) needs."</p> <p>The 1/24/13 Elopement Risk Assessment indicated Resident #49 was at risk for elopement due to the following: schizoaffective disorder, ambulates independently, difficulties accepting facility placement, and verbally expresses a desire to go home.</p> <p>The 1/24/13 elopement risk care plan indicated, "High risk - hx (history) previous elopement @ other facility." The goal was for Resident #49 to have no episodes of elopement. Interventions were to provide activities, redirect resident, and remind resident this was short term placement. The discipline responsible for implementing this care plan was "all personnel."</p> <p>The 1/26/13, 10:30 a.m. nurse's note for Resident #49 indicated, "...just wanting to know when can he go home."</p> <p>The 1/26/13, 3:30 p.m. nurse's note indicated, "Resident was noted missing from facility at 11:25. Facility and grounds were search (sic) per</p>		<p>the facility. This education is also provided during new employee orientation and will be repeated quarterly during facility inservices.</p> <p>IV. The Administrator or his designee is conducting quality improvement audits. This audit includes checking the facility exit doors to ensure they are secure. 100% of the exit doors are being audited at different times of the day 3 times per week for 30 days; then weekly for 30 days; then monthly for 6 months. In addition, checking security of the exit doors are part of the routine facility rounds completed by administrative personnel on a daily basis. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary</p>		

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	<p>staff. Writer called DON (Director of Nursing) and police at 11:30. QMA (Qualified Medication Aide) got in her car and went looking for resident...11:42 QMA called facility stated she had resident with her and was on her way back to the facility. 12 N (noon) QMA and resident return (sic) to facility...Writer and resident went to resident room. VS (vital signs) taken...body assessment done. No apparent injury. Resident stated he was okay...Writer asked resident how did you get out. Resident stated I just walked out the door. Was that okay. Writer explained to resident he needs to stay here with us so we can take care of him and keep him safe. Resident has one on one care at this time."</p> <p>The 1/26/13 Reportable Occurrence Investigation Report Form completed by the Administrator was provided by the Administrator on 2/27/13 at 3:15 p.m. It indicated, "Summary/Results of investigator's findings: On 1-26-13 at 11:30 a.m. (name of Resident #49) eloped from the facility. A search of the neighborhood was initiated. (Name of local police department), the DON, HFA (Health Facility Administrator) were notified of the event. At 12:15 p.m. with no injuries noted (sic). Upon investigation it was</p>						

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	<p>determined that the last person to use the door slowed the door down so that it wouldn't slam. This caused the magnet not to catch the metal plate to ensure that the door would lock. (Name of Resident #49) has been placed on 1:1 (one to one supervision) until further notice. The staff has been inserviced on ensuring the doors are locked every time that they enter or exit the facility."</p> <p>An interview was conducted with the Administrator on 2/27/13 at 2:12 p.m. regarding how it was determined that the last person to use the door slowed the door down so it wouldn't slam causing the magnet not to catch the metal plate to ensure that the door would lock. He indicated, "First we adjusted the weather stripping to make sure that wasn't the problem. It wasn't. We checked all doors. We checked the timing of the door. It was okay. What happened was a staff person slowly let the door shut on her way in and there wasn't enough pressure for the magnet to get close enough to catch the metal." He indicated the Activity Assistant saw CNA #4 come back in from break and slow the door when closing it at about 10:45 a.m. at which time, Resident #49 was at the front door trying to use the telephone. The Administrator</p>			

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	<p>indicated, it was concluded that Resident #49 eloped sometime between 10:45 a.m. and 11:25 a.m. and the park at which he was found was 4 blocks away. Regarding whether or not anything was done to more closely monitor Resident #49 after his 10:30 a.m. indication of wanting to know when he could go home, the Administrator stated, "Not that I know of. They try to keep him busy with activities, but at the time, I think he was trying to use the telephone." The Administrator indicated Resident #49 was pleasantly confused. He stated, "We make all of our staff aware of who is an elopement risk." He indicated everyone, including CNA #4, was aware he was an elopement risk and the signs on both sides of the front door have always been up. The Administrator indicated CNA #4 was "apologetic" when he talked to her afterwards. He indicated neither CNA #4 nor himself were aware that the front door wouldn't close all the way if closed too slowly. He indicated the door could not be adjusted any further, even to prevent a non-latch if the door was shut too slowly.</p> <p>An observation of the front door from which Resident #49 was determined to have eloped was made on 2/27/13</p>				

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	<p>at 2:25 p.m. The signs taped to both sides of the front door indicated, "STAFF!!! YOU ARE RESPONSIBLE (sic) TO PUSH AND PULL THE DOOR BEHIND YOU WHEN EVER YOU OPEN IT TO ENSURE THAT THE DOOR IS FULLY CLOSED AND LOCKED BEHIND YOU." The Administrator opened the door via a code on the keypad and then slowly shut it. The magnet at the top of the door did not catch and the door could be reopened. The light on the keypad indicated green when open and red when locked.</p> <p>During an interview with the Activity Assistant on 2/27/13 at 2:54 p.m., she indicated the last person she saw come in the front door on 1/26/13 around 10:45 a.m. was CNA #4 and that she slowly closed the door upon entrance. She indicated, in her opinion, there may not have been enough pressure exerted upon the door after CNA #4 came in to ensure it was locked. The Activity Assistant indicated she was aware that a lack of pressure exerted upon the door may cause the door not to lock. She stated, "Some people may not be aware that the door may not shut all the way, but I am."</p> <p>During an interview with the DON and</p>						

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	<p>the Administrator on 2/28/13 at 12:56 p.m., the DON indicated the only people who knew the code to the doors at the facility were the staff and transportation, but that transportation used the side door, not the front door. She indicated the staff were responsible for letting people in and out of the facility and to ensure the door was locked after entrance and exit.</p> <p>This federal tag relates to complaint IN00123409.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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. Based on observation, record review and interview, the facility failed to provide a medication as ordered for 1 out of 10 residents reviewed for unnecessary medications. Resident #36.</p> <p>Findings included:</p> <p>Resident #36's clinical record was reviewed on 2/26/2013 at 10 a.m. The resident's diagnoses included, but were not limited to; chronic schizophrenia paranoid, generalized anxiety disorders, diabetes, chronic obstructive pulmonary disease,</p>	F000425	<p>F425 483.60(a)(b) PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH</p> <p>It is the practice of Rural Health Care Center to provide routine and emergency drugs and biological to its residents; and to provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident.</p>	03/22/2013			

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	<p>cardiac dysrhythmia, dementia.</p> <p>A review of the physician orders recapitulation dated February 2013 indicated, "Lithium Carbonate 150mg cap 1 capsule by mouth twice daily with 300mg cap to = 450mg."</p> <p>A "Behavior Monitoring Record" dated 2/9/13 at 4:30 a.m. indicated, "cursing and talking about hitting."</p> <p>Resident #36's medication administration record (MAR) indicated, by the circle around the nurse's initials and notation on the back of the MAR, that he did not receive his Lithium 150mg on 2/9/2013, 2/10/2013, and 2/11/2013 as ordered, because the medicine was not available according to what was written on the back of the MAR. On 2/11/2013 a written explanation on the back of the MAR indicated that Lithium carb 150mg was "not in."</p> <p>A "Medication Reorder Strip Sheet," provided by the Director of Nursing (D.O.N.) on 2/28/2013 at 1:30 pm, indicated, Resident #36's Lithium Carbonate 150mg was hand written as a medication to reorder. The medication reorder strip sheet was dated 2/9/2013. The medication reorder strip sheet did not have the</p>		<p>I. Resident #36 is receiving the medication as ordered.</p> <p>II. Residents receiving medications have the potential to be affected by medications unavailable.</p> <p>III. The policy for reordering medications has been reviewed and updated to include calling the pharmacy directly if medication is unavailable. Licensed nurses were educated on this policy.</p> <p>IV. The DON or her designee is conducting quality improvement audits. This audit also includes checking medication and treatment records for any unavailable doses; and then the prompt re-ordering of the medication and physician notification where appropriate. A random sample of 5% of residents is being audited weekly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary.</p>	

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	<p>name of the nurse authorization written in the space provided and it did not have the facility name written in the space provided.</p> <p>An interview, on 2/27/2013 at 1 pm, with RN #3, indicated, when a medication is out, the pharmacy they use is contacted by sending a medication reorder using the fax machine.</p> <p>An interview, on 2/27/2013 at 3:30 pm, with RN #5, confirmed that the circle around the initials on the medication administration record (MAR) indicated that the medication was not given, and the reason was written on the back of the MAR.</p> <p>An interview, on 2/28/2013 at 9 am, with Pharmacist #6, indicated, that they are available to deliver the necessary medications to the facility every day including most of the day on Saturdays. Otherwise, they have another pharmacy able to deliver the medications needed on Sundays.</p> <p>An interview, on 2/28/2013 at 9:15 am, with QMA #2, indicated the facility receives a 30 day supply of medication for each resident and when it gets down to 10 days of medication for a particular resident, a</p>						

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	<p>reorder is sent by their fax. On Fridays she usually checks to make sure medications are available for the residents she is responsible for and reorders medications that are out.</p> <p>An interview, on 2/28/2013 at 9:30 am, with the D.O.N. indicated, that in regard to the Lithium for Resident #36, it was something she is checking into and this was just brought to her attention yesterday. The D.O.N. indicated, that she is not sure what exactly happened with the reordering of the Lithium for resident #36 and is not sure if it was a problem on the facility's end or on the pharmacy's end that something went wrong.</p> <p>3.1-25(a)</p>				

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F000465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure bathroom tiles were properly maintained. This had the potential to affect 7 of 39 residents residing in the facility. (Resident #33, #19, #15, #36, #32, #38, #14)</p> <p>Findings include:</p> <p>1. During a random observation, on 2/26/13 at 10:28 a.m., a shared bathroom for rooms 7 and 8 had a cracked bathroom tile next to the door frame. The crack was halfway through the tile and appeared to be coming loose. 4 residents resided in rooms 7 and 8.</p> <p>During random observations, on 2/27/13 at 3:00 p.m. and 2/28/13 at 12:05 p.m., the above bathroom tile was still cracked and was coming up at the edge near the door frame.</p> <p>2. During a random observation, on 2/25/13 at 2:59 p.m., a section of a bathroom tile, near the doorway of a shared bathroom for rooms 1 and 2, was missing . 3 residents resided in</p>	F000465	<p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT</p> <p>It is the practice of Rural Health Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and public.</p> <p>I. The bathroom tiles that potentially affected Residents #33, #19, #15, #36, #32, #38, & #14 were replaced.</p> <p>II. All residents have the potential to be affected. The Maintenance Director has checked all resident bathrooms to ensure tiles are in good repair.</p> <p>III. The Maintenance Director has a preventive maintenance program in place. This program has been updated to include monitoring resident bathroom</p>	03/22/2013			

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	<p>rooms 1 and 2.</p> <p>During random observations, on 2/27/13 at 3:02 p.m. and 2/28/13 at 12:15 p.m., the above tile was still missing a section, near the doorway.</p> <p>During an interview, with the Maintenance Director, on 2/28/13 at 12:15 p.m., he indicated when a tile has a crack in it or was missing, he would replace it. He also indicated the above bathroom tiles needed to be replaced and he will fix them that day.</p> <p>3.1-19(f)</p>		<p>tiles.</p> <p>IV. The Administrator or his designee is conducting quality improvement audits. This audit includes checking resident bathrooms including floor tiles for good repair. A random sample of 5% of resident rooms is being audited weekly for 30 days; then monthly for 6 months. Additional audits will be completed based upon level of compliance. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendation if necessary.</p>		