STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN UNITED METHODIST COMMUNITY	1070 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 26, 27, 28, 29, 30, and December 3, 4, and 5, 2012. Facility number: 001127 Provider number: 155771 AIM number: 200247220 Survey team: Leia Alley, RN, TC Marcy Smith, RN Patty Allen, BSW Dinah Jones, RN Census bed type: SNF 28 NF 98 SNF/NF 14 NCC 40 Residential 147 Total 327 Census payor type: Medicare 18 Medicaid 73 Other 236 Total 327 Residential Sample: 10	F0000	The statements made on this Plan of Correction are not an admission to and do no constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.	

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

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

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on December 11, 2012; by Kimberly Perigo, RN.			

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F0280 SS=D	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. 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. Based on observation, record review, and interview, the facility failed to ensure careplanned weight loss interventions of nutritional supplements had been revised upon a resident's refusal to consume them for 1 of 3 residents who met the criteria for nutrition review in a sample of 40. (Resident #95) Findings include: The record of Resident #95 was reviewed on 11/30/12 at 11:30 a.m. Diagnoses for Resident #95 included,	F0280	The licensed nursing staff and all interdisciplinary team members understand the importance of following the resident's plan of care including revising care plan interventions when the current interventions are not working. During the annual survey the survey team identified the facility was out of compliance with the regulation of F280. One (1) of three (3) residents reviewed was cited. Resident #95 lacked documentation to indicate the care plan was revised to reflect that the intervention of a nutritional supplement was refused by Resident #95. A. In this case, Resident #95 had progressively lost weight and	12/24/2012

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	but were not limited to, stroke with hemiparesis, dysphagia, coronary artery disease, diabetes mellitus, hypothyroidism, gastroesophageal reflux disorder and dementia. A review of Resident #95's monthly weights indicated the following: January, 2012 123.5 lbs. (pounds) February, 2012 122 lbs. March, 2012 123 lbs. April, 2012 120 lbs. May, 2012 119.8 lbs. June, 2012 120.8 lbs. July, 2012 115.6 lbs (4.3% loss in 30 days) August, 2012 111.6 lbs (3.5%loss in 30 days) September, 2012 107 (4% loss in 30 days, 11.4% loss in 90 days) October, 2012 103 lbs (3.7% loss in 30 days, 13% in 180 days) November, 2012 98 lbs. (4.8% loss in 30 days, 18% loss in 180 days) A care plan for Resident #95, originally dated 1/31/12, indicated a problem of, "Need for Weight Stability." The goal was, "[name of resident]'s weight will be stable x 90 days. Goal date: 12-13-2012." Interventions included, "Monitor weight & other nutrition parameters ... Provide nutrition supplement as		refused most food and supplements as their disease progressed. Although the facility took many steps/measures to try to prevent weight loss and encourage Resident #95 to increase their caloric intake, the facility staff failed to document thoroughly those interventions and Resident #95's response to them. Resident #95's food consumption will be monitored by nursing staff. Inter-disciplinary team will monitor consumption reports of meals and supplements on a weekly basis to ensure Resident #95 is consuming the proper amount of food. The care plan will be updated weekly to reflect Resident's choices and inter-disciplinary team recommendations. Food likes and dislikes will also be discussed with family members if applicable. B. All residents have the potential to be affected by weight loss and potentially can have care plan interventions that need evaluated and updated. All residents will be reviewed by December 24, 2012 to ensure that if they have had a significant weight loss their care plans and interventions are updated to reflect current interventions and their effectiveness. If the current interventions are not effective then new interventions will be added. Current interventions will be reviewed as needed at a minimum of weekly during the	

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	ordered (...name of supplement... 120 ml [milliliters] @ HS (bedtime)." The nutrition supplement intervention was updated on 10/10/12 to 3 times per day, and on 11/30/12 to 4 times per day. An "Evaluation" dated 10/5/12 indicated, "Weight loss of 14% past 6 months ... continues to refuse to eat ... will sometimes drink [name of supplement] with much encouragement..." During an observation of Resident #95 at the lunch meal on 11/27/12 at 12:40 p.m., she did not eat anything. A physician order dated 10/2/12, indicated Resident #95's nutritional supplement was increased to 120 ml's., 3 times per day. A physician order dated 11/13/12, indicated Resident #95's nutritional supplement was increased to 4 times per day. A Dietary Progress Note dated 11/12/12, no time indicated, written by the Registered Dietician, indicated "...Has had a 21.8# (18.1% [loss]) in 180 days - significant wt. [weight] loss ... Recommend [increase] [name of supplement] to 120 cc QID [4 times per day.] Refusing meals + supplements."		daily unit meetings with the Interdisciplinary Team. C. The Interdisciplinary Team has met and will implement a new standard when addressing weight loss that will improve communication between the entire Interdisciplinary Team to ensure that all disciplines are aware when a resident is having a significant weight loss and what measures are being utilized. Any resident with a significant weight loss will be put on weekly weights and reviewed at a minimum of weekly to re-assess the effectiveness of the current care plan intervention that is in place. These meeting and their content will be documented in a dietary binder and on the daily meeting form by the unit manager or designee. Any new intervention will be added to the resident's care plan. D. Unit manager or designee will conduct an audit review of any resident with significant weight loss at the beginning of each month following monthly weights to ensure the care plans are kept current and accurate. E. Collected data from the audit process will be reviewed at weekly standards of care meeting and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. F. Substantial compliance date: December 24,	

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	A facility policy dated 4/27/05, received from the Director of Nursing on 12/3/12 at 1:30 p.m., titled "Nutritional Intervention Procedure," indicated "...Residents are considered to be at nutritional risk if they have any of the following ... b. Significant or severe weight loss ... 6. A licensed nurse is responsible for ... c. Assigning CNA's [Certified Nursing Assistants] to weekly weigh residents ... The Consulting or Registered Dietitian is responsible for: a. Recommending nutritional interventions to meet the resident's identified needs ... b. Meeting with the D.O.N. at the time of each visit to discuss residents at nutritional risk..." During an interview with Resident #95's Unit Manager on 12/3/12 at 11:30 a.m., she indicated they have an Interdisciplinary Meeting every week day where residents at nutritional risk would be discussed. A review of the Daily Interdisciplinary Meeting notes since 10/4/12, indicated Resident #95 had only been discussed once, on 10/4/12. She indicated weekly weights were not done on the resident but, "Weekly weights should have been done, in hindsight."		2012.	

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	During an interview with the Registered Dietician on 12/3/12 at 2:55 p.m., she did not indicate any other nutritional interventions were considered or implemented on 11/12/12 when she documented in her Dietary Progress Note her recommendation of increasing Resident #95's supplement to 4 times per day and that the resident was, "refusing meals + supplements." She also indicated she had not met with the DON during her weekly visits to discuss residents at nutritional risk, as indicated by facility policy. 3.1-35(d)(2)(B)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review,	F0441	During the annual survey, the survey team had two (2)	12/24/2012

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	and interview the facility failed to ensure staff washed their hands prior to and wore gloves during the administration of eye drops for 1 of 2 residents observed for eye drop administration. (Resident #229). The facility also failed to ensure employees held linens away from their body and clothing to prevent the spread of infections. Findings include: 1) During an observation of eye drop administration on 11/30/12 at 9:20 a.m., R.N. #1 took a bottle of eye drops into the room of Resident #229. She proceeded to apply a drop into the resident's eye without washing her hands or applying gloves, prior to the administration. During an interview with RN #1 on 11/30/12 at 9:30 a.m., she indicated, "I should have worn gloves and washed my hands, I always do." An undated facility policy, titled "Eye Medication Administration," received from the Director of Nursing on 11/30/12 at 10:50 a.m., indicated "...Implementation ... Perform hand hygiene and put on gloves..."		observations in a period of eight (8) days that identified the facility was out of compliance with F441. Two (2) staff members were identified as not following the facility policy and procedures for infection control. One (1) observation was a licensed nursing staff member that was observed to give eye drops to a resident without first washing her hands or donning gloves. The second observation was a dietary staff member who was carrying clothing protectors into the dining room while holding the protectors against their body. Both of these incidents were isolated and do not demonstrate a break in the facility system versus those two (2) staff members needing education. A. At least three (3) other medication passes were observed by the survey team with no concerns regarding infection control. Clearly, this was not a pattern or a systems problem but an isolated incident and the error of a single nurse. The licensed nursing staff member has been counseled, re-educated and will complete an infection control in-service. It is the expectation and the policy of the facility that all nursing personnel who are delivering medications, including eye drops, wash their hands and don gloves when appropriate. B. The situation with the dietary	

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	2) During an observation on 11/29/12 at 2:00 p.m., Dietary Aide #1 (DA) was observed to be carrying clothing protectors in her hands and arms. DA #1 was carrying a stack of clothing protectors so large that she held them against her clothing, apron, and face. A facility policy, undated and titled "Infection Control Policy" indicated "All facility personnel are required to ... use appropriate barrier precautions to prevent transmission of infections." 3.1-18(l) 3.1-19(g)(1)		staff member holding the clothing protectors against their body was also an isolated occurrence. Linens are handled throughout the facility numerous times a day on all six (6) units and no other infractions were observed by the survey team. The dietary staff member in question was counseled, re-educated and will complete an infection control in-service. It is the expectation of the facility that all facility staff follow the policies and procedures for handling resident linens, which includes using the appropriate barriers when necessary to prevent the spread of infections. C. All facility staff members have the potential to be non-compliant with the facility .policy and procedure regarding infection control. Each department of the facility includes guidelines relevant to their department in the orientation process for each employee. Infection control in-servicing and reviewing of facility policies and procedures will continue on an annual and as needed basis. D. Director of Nursing, unit manager and/or designee will conduct an audit to monitor and ensure that all facility staff is compliant with appropriate infection control techniques, specifically administering eye drops and carrying clothing protectors into the resident dining	

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			areas. These audits will occur weekly for one month, bi-weekly for one month and then monthly thereafter. E. Collected data from the audit process will be reviewed monthly and reported to the Quality Improvement Committee for further recommendations. The director of nursing or designee is responsible for assuring data presentation. F. Substantial compliance date: December 24, 2012.	

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R0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 26, 27, 28, 29, 30, and December 3, 4 and 5, 2012. Facility number: 001127 Provider number: 155771 AIM number: 200247220 Survey team: Leia Alley, RN, TC Marcy Smith, BSW Patty Allen, BSW Dinah Jones, RN Census bed type: SNF 28 NF 98 SNF/NF 14 NCC 40 Residential 147 Total 327 Census payor type: Medicare 18 Medicaid 73 Other 236 Total 327 Residential Sample: 10	R0000	The statements made on this Plan of Correction are not an admission to and do no constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.	

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R0300	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to ensure stored refrigerated medications were labeled for 1 of 4 medication storage areas observed. (2nd floor, back hall medication storage area) Findings include: During an observation on 12/5/12 at 11:10 a.m., with Licensed Practical Nurse (LPN) #2, 4 generic syringes [non-labeled] containing a small amount of clear fluid were observed in the unlocked medication refrigerator. At that time LPN #2 indicated the 4 syringes were, "flu vaccines." LPN #2 indicated she did not know why the 4 syringes were not labeled. A facility policy dated 5/16/06, titled Pharmaceuticals Storage, received from the Residential Unit Manager on 12/5/12 at 11:55 a.m. indicated, "...II. Drug Storage ... 2. Medications are	R0300	During the annual survey, the survey team observed the facility was out of compliance with R300. This observation was made in one (1) out of four (4) medication rooms reviewed. It was noted by the survey team that four (4) syringes were in the medication refrigerator and contained medication in them. These syringes were not labeled to indicate what medication they contained, although they were identified as containing the flu vaccination. A. The syringes were removed from the refrigerator and destroyed as they were not labeled correctly. All residential nursing staff has been re-educated to ensure no medication is stored in an unmarked container without proper labeling as indicated in the facility policy and procedure. B. Director of Nursing, unit manager and/or designee will conduct an audit to monitor and ensure that all facility staff is compliant with storing of medications with appropriate	12/24/2012

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	to be stored in the original container as supplied by the pharmacy. 3. Staff shall not transfer medications from one container to another..."		labeling. These audits will occur weekly for one month, bi-weekly for one month and then monthly thereafter. 1.Collected data from the audit process will be reviewed monthly and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. 1.Substantial compliance date: December 24, 2012.	

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R0304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review the facility failed to ensure medications were stored in a locked environment for 1 of 4 medication storage areas observed. (2nd floor, back hall medication storage area) Findings include: On 12/5/12 at 9:05 a.m., an unlocked medication refrigerator was observed in the 2nd floor, back hall nurses' station/chart room. This room did not have a door on it which could be opened, closed, or locked. Next to the entrance to the room there was a sign which read, "Staff Only." No staff was observed nor within sight of the room between 9:05 a.m. and 9:18 a.m. On 12/5/12 at 11:05 a.m., Resident #118 was observed entering the unoccupied nurses' station/chart room, 2nd floor, back hall. Resident	R0304	During the annual survey, the survey team observed the facility was out of compliance with R304. This observation was made in one (1) out of four (4) medication rooms reviewed. It was noted by the survey team that one (1) of the medication refrigerators did not have a means to lock it appropriately when a staff member was not present. A. The refrigerator is being moved into an area that has a door that can be locked. This area will only be accessible only to appropriate personnel assigned to that unit. B. Director of Nursing, unit manager and/or designee will conduct an audit to monitor and ensure that all medication storage areas, including medication refrigerators, are locked and secure as per policy and procedure. These audits will occur weekly for one month, bi-weekly for one month and then monthly thereafter.	12/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2012
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131	

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	#118 left with a styrofoam cup. During an interview at that time with Licensed Practical Nurse (LPN) #2, who was in the room across the hall, LPN #2 indicated Resident #18 liked to take the cups back to her room for water. During an observation of the 2nd floor, back hall medication storage refrigerator on 12/5/12 at 11:10 a.m., with Licensed Practical Nurse (LPN) #2, 15 opened vials of insulin and 4 syringes containing flu vaccine were observed stored in this unlocked medication refrigerator. A facility policy dated 5/16/06, received from the Residential Unit Manager, titled "Pharmaceuticals Storage," indicated "...II. Drug Storage: All drugs shall be stored in a medication cart, cabinet or room that shall be kept locked at all times when not attended by an authorized person..."		1.Collected data from the audit process will be reviewed monthly and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. 1.Substantial compliance date: December 24, 2012.	

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R0351	410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation, interview, and record review the facility failed to store clinical records in a manner that would ensure confidentiality in 1 of 4 chart rooms observed for storage of clinical records. (2nd floor, back hall chart room) Findings include: During an observation of the nurses' station/chart room on the 2nd floor, back hall, on 12/5/12 at 9:05 a.m., 4 current charts belonging to Residents #113, #84, #114, and #90 were sitting on the desk in full view of anyone who came into the nurses' station/chart room. There was a sign on the wall next to the room entrance which indicated, "Staff only." There was no door going into this room that could be opened or closed. Other charts were observed in unlocked file cabinets in the room. No staff was observed in the room between 9:05 a.m. and 9:18 a.m. There was a coffee pot and styrofoam cups in the	R0351	During the annual survey, the survey team observed the facility was out of compliance with R351. This observation was made in one (1) out of four (4) chart rooms reviewed. It was noted by the survey team that the file cabinets that housed resident clinical records were not kept locked and secure, therefore, potentially allowing any one access to them. A. The resident files have all been placed in a locked filing cabinet. All residential nursing personnel has been re-educated in regards to all resident clinical records remaining locked up and secure at all times in their absence. B. Director of Nursing, unit manager and/or designee will conduct an audit to monitor and ensure that all resident clinical records are kept locked and secure in the absence of facility personnel as per policy and procedure. These audits will occur weekly for one month, bi-weekly for one month and then	12/24/2012

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	room sitting on a shelf. On 12/5/12 at 11:05 a.m., Resident #118 was observed entering the otherwise unoccupied nurses' station/chart room, 2nd floor, back hall. She left with a styrofoam cup. During an interview at that time with Licensed Practical Nurse (LPN) #2, who was in the room across the hall, she indicated Resident #118 liked to take the cups back to her room for water. During an interview with the Unit Manager on 12/5/12 at 11:20 a.m., she indicated the file drawers were usually kept locked. She indicated, "That has been a problem." An undated facility policy, received from the Director of Nursing on 12/5/12 at 4:15 p.m., titled "Medical Record Policy," indicated "...Retention and Storage 1. All medical records are stored in a manner that is free from water damage, insects and theft, and are protected from loss, destruction and unauthorized use. Records are so stored that information contained in the records is kept confidential."		monthly thereafter. 1.Collected data from the audit process will be reviewed monthly and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. 1.Substantial compliance date: December 24, 2012.	

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