

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 4, 5, 6, 7, &amp; 8, 2014</p> <p>Facility number: 010478 Provider number: 155649 AIM number: 200197620</p> <p>Survey team: Cheryl Mabry, RN-TC Diana McDonald, RN Angela Patterson, RN</p> <p>Census bed type: SNF: 13 SNF/NF: 62 Total: 75</p> <p>Census payor type: Medicare: 12 Medicaid: 47 Other: 16 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 18, 2014; by Kimberly Perigo, RN.</p>	F000000	Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

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:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

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

F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure resident's had their call lights with in reach for 2 of 2 residents randomly observed. (Resident #15, and #31).</p> <p>Findings include:</p> <p>1.) Resident #15's clinical record was reviewed on 8/8/2014 at 9:30 a.m. Diagnoses included, but were not limited to: congestive heart failure, hypertension, diabetes, hyperlipidemia, dementia, depression, and chronic obstructive pulmonary disease. On 6/10/2014, Resident #15 had a Brief Interview for Mental Status (BIMS) of 8; which indicated moderate cognitive impairment.</p> <p>On 8/4/2014 at 2:27 p.m., an observation of Resident #15's room indicated the call</p>	F000246	<p>At the time of the event the call lights were put within reach and the residents were not negatively affected by the practice. Other residents call lights were checked and were appropriately in place. Education to facility staff was provided on making sure that call lights were within reach. Incorporated into our facility QA rounds will be random call light observations of call light placement (see attachment A). These random observations will be completed on all shift including weekends. A minimum of 5 observations will be completed weekly for 2 months then quarterly. The results of the audits will be reviewed in our QA process with a subsequent plan to be developed as necessary. The systematic changes will be completed by September 7, 2014.</p>	09/07/2014
-----------------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>light was not in reach hanging over the call light system; located on the wall. Requested CNA #6 to come to Resident #15's room. When CNA #6 was asked if the Resident could reach her call light, CNA #6 indicated no she couldn't. CNA #6 then placed the call light with in reach of Resident #15.</p> <p>On 8/8/14 at 10:35 a.m., an observation of Resident #15's room indicated resident was resting in her bed. The call light was on the floor. Resident #15 indicated she could not reach the call light. The Maintenance man picked up the call light and clipped the call light to the bed sheet next to Resident #15's hand.</p> <p>On 8/8/14 at 10:36 a.m., an interview with the Maintenance man indicated Resident #15's call light was not in reach. The call light should have been placed so Resident #15 could reach it.</p> <p>2.) Resident #31's clinical record was reviewed on 8/8/2014 at 9:45 a.m. Diagnoses included, but were not limited to: anemia, hypertension, gastroesophageal reflux disease, diabetes, hyperlipidemia, hypothyroidism, arthritis, osteoporosis, dementia, and depression.</p> <p>On 6/5/2014 Resident #31 had a BIMS (Brief Interview for Mental Status) of 8,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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			
F000279 SS=D	<p>which indicated the resident was moderately cognitively impaired.</p> <p>On 8/8/14 at 10:45 a.m., an observation of Resident #31's room, the call light was behind the bed. Resident #31 indicated she could not reach the call light. The Maintenance man retrieved the call light and placed the call light in reach of Resident #31.</p> <p>On 8/8/14 at 10:45 a.m., an interview with the Maintenance man indicated the call light should be in reach of the each resident at all times.</p> <p>On 8/8/14 at 11:30 a.m., review of policy provided by the Administrator titled "Resident Rights Guidelines" no date, Administrator indicated this was the policy currently used at the facility. The policy indicated, "... Place a call light with in reach and instruct resident to call for assistance, if needed..."</p> <p>3.1-3(v)(1)</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</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>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 ensure the careplan for urinary continence was accurate as indicated by the policy for a resident who was incontinent of urine in that Resident #49's MDS (Minimum Data Set) assessment indicated Resident #49 as being frequently incontinent of urine and the careplan for urinary continence did not identify the assessed incontinence for 1 of 2 residents reviewed for urinary incontinence. (Resident #49).</p> <p>Findings include:</p> <p>Resident #49's clinical record was reviewed on 8/8/2014 at 10:14 a.m. Diagnoses included, but were not limited to: osteoarthritis, diabetes mellitus, blindness, chronic ischemic heart disease, hypertension, hypothyroidism, dyspepsia, spinal stenosis, lumbago, and anxiety.</p>	F000279	<p>Resident number 49 care plan was reviewed and updated to reflect her current status. Incontinent residents have the potential to be effected. Incontinent resident's bowel and bladder assessments have been reviewed and their care plans updated to reflect their current status as appropriate. IDT reeducated on review of bowel and bladder assessments and updating care plans to reflect the resident's current status. Bowel and bladder assessments and continence care plans will be reviewed during IDT walking rounds(facility quarterly care plans), or significant change condition and updated the plan of care as appropriate. (see attachment B) The DON or designee will audit 5 resident's bowel and bladder assessments weekly x 4 weeks, then 5 monthly x2 months, then 5 quarterly. Results of the audits will be</p>	09/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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 quarterly MDS (Minimum Data Set) assessment dated 6/27/2014, assessed Resident #49 as frequently incontinent of urine and no toileting program was in place.</p> <p>On 8/8/2014 at 10:30 a.m., the Administrator provided the careplan and Bowel &amp; Bladder Assessment and Management for Resident #49. The careplan titled "CONTINENCE CARE PLAN" initiated on 3/27/2014 and updated on June of 2014, the careplan indicated Resident #49 had "no urine incontinence, no B/B [bowel/bladder] Retraining/Individual Schedule, no Prompted Toileting or Scheduled T. [Toileting Plan], no Incontinence Mgmt. [Management] program." Interventions included, but were not limited to: "Monitor and record bowel and bladder patterns each shift, regularly assess bowel and bladder status and management programs, report to MD [medical doctor] abnormal symptoms or conditions...."</p> <p>The "Bowel &amp;Bladder Assessment and Management" tool indicated on 6/27/2014, a score of 4, which indicated the resident was continent; no further intervention required.</p>		<p>reviewed in our QA process with a subsequent plan to be developed as necessary. The systematic changes will be completed by September 7, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460		
(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 8/8/2014 at 11:05 a.m., LPN #2 provided the facilities "ACTIVITY OF DAILY LIVING Nurse Assistant Care Record" for Resident #49's bowel/bladder continence and the computerized care plan titled "ADL [Activities of Daily Living]- Toileting."</p> <p>The ADL Nursing Assistant Care Record indicated:</p> <p>On day shift no charting from 8/1-8/5, 2014</p> <p>On 8/6/2014 continent and incontinent of bladder.</p> <p>On evening shift No charting on 8/1, 8/2, 8/4, 8/5, 8/6, 2014</p> <p>On 8/3, 8/4, 8/7, 2014 continent and incontinent bladder.</p> <p>On night shift No charting for 8/2, 8/4, 2014</p> <p>On 8/1, 8/3, 8/5, 8/6, 8/7, 2014 incontinent of bladder.</p> <p>The "ADL Plan of Care-Toileting" for Resident #49 indicated the resident was continent of bladder. No scheduled urine program or bladder training program in place. The careplan indicated Resident #49 does not wear briefs.</p> <p>On 8/8/2014 at 10:40 a.m., an interview with CNA (Certified Nursing Assistant) #2 indicated Resident #49 was always</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>continent during the day, but is always incontinent (wet) when they get her out of bed in the morning.</p> <p>On 8/8/2014 at 10:45 a.m., an interview with LPN #2 indicated Resident #49 is incontinent in the morning when the CNA's get her out of bed. At that time, she indicated Resident #49 was continent of bladder during the day and uses a brief for possible leakage of urine. LPN #2 indicated she would do a change of condition report for Resident #49 indicating the resident was frequently incontinent of urine.</p> <p>On 8/8/2014 at 11:00 a.m., an interview with CNA #1 indicated Resident #49's bed was wet when they get her up in the morning. At that time CNA #1 indicated Resident #49 is continent of bladder during the day and wears a brief in case of urine leakage.</p> <p>On 8/7/2014 at 1:55 p.m., the Director of Nursing provided the Careplan Comprehensive and Careplan Episodic, dated 2008, and indicated the policy was the one currently used by the facility. The Careplan Comprehensive policy indicated: Policy "It is the policy of this facility to develop, in conjunction with the resident and /or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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>representative, the Comprehensive Resident Careplan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability and quality of life...It is reviewed and revised by the Interdisciplinary Team quarterly, following completion of the MDS assessment, and following assessment for significant change.</p> <p>Purpose To direct the IDT [staff team] toward achieving and maintaining optimal resident health, function and quality of life.</p> <p>Procedure ....3. The care plan becomes a comprehensive tool for the IDT to utilize as a reference for resident specific problems and approaches to establish guidance on meeting the individual needs of the resident..."</p> <p>The Careplan, Episodic, indicated: Policy "It is the policy of this facility to develop an episodic/short term care plan for acute temporary changes and/or condition... Procedure 1. Acute short-term changes in resident routine care will be documented on the episodic/short term care plan form."</p> <p>3.1-35(b)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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
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 interview and record review, the facility failed to ensure Resident #35's careplan was updated as indicated by the policy/procedure after the resident fell for 1 of 4 residents reviewed for accidents. (Resident #35)</p> <p>Findings include:</p>	F000280	Resident number 35 care plan was reviewed immediately and updated to reflect her current status. Residents who have fallen have the potential to be effected. Residents fall assessments have been reviewed and their care plans updated to reflect their current status as appropriate, IDT re-educated on review of fall assessments and	09/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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 #35's clinical record was reviewed on 8/7/2014 at 10:14 a.m. Diagnoses included, but were not limited to: hypertension, anemia, Alzheimer's, esophageal reflux, angina pectoris, and vitamin D deficiency.</p> <p>On 7/23/2014 at 9:15 a.m., Resident #35 had a fall and neurochecks (a brief neurologic assessment ordered by the physician to be performed every 4 hours on patients that may have evolving disease, such as stroke. The level of consciousness is evaluated as alert and oriented, lethargic, stuporous, or comatose. The movements of the extremities are determined to be voluntary or involuntary. The pupils of the eyes are observed for equality of dilation, reactivity to light, and ability to accommodate, Mosby's Medical Dictionary, 8th edition, copyright 2009, Elsevier.) were obtained. Reviewed the 15 minute check list dated 7/23/2014 and 7/24/2014.</p> <p>Reviewed on 8/8/2014 at 11:00 a.m., of the facilities form "Change of Condition Report-Sustained or suspected fall" dated 7/23/2014. The form indicated Resident #35 fell forward from her wheelchair to the floor. The fall was witnessed by a staff member and occurred in Resident #35's room. Resident #35 was unable to</p>		<p>updating care plans to reflect the resident's current status. Falls will be reviewed next business day during morning meeting with care plans updated to reflect current status. (see attachment c). The DON or designee will audit 5 residents with falls or less if fewer than 5 falls for the week assessments and updated care plans weekly x 4 weeks, then 5 x monthly x 2 months, then 5 quarterly. Results of the audits will be reviewed in our QA process with a subsequent plan to be developed as necessary. The systematic changes will be completed by September 7, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>communicate what occurred. Vitals signs were normal. Three abrasions were obtained during the fall to the head, left knee, and left middle arm. Physician and family were notified of fall.</p> <p>The fall care plan dated 6/16/2014, for Resident #35 indicated a focus "the resident is moderate risk for falls related unaware of safety needs, gait/balance problems, incontinence. Goals: The resident will be free of falls through review date." Interventions included: "Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encouraged the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. Educate the resident/family/caregivers about safety reminders and what do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure the the resident is wearing appropriate footwear when mobilizing in wheelchair. Follow facility fall protocol."</p> <p>No updated interventions to prevent recurrence of Resident #35 from falling was indicated on fall care plan in the clinical record post fall on 7/23/2014, when Resident #35 leaned forward in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>wheelchair and fell to the floor and obtained three abrasions.</p> <p>On 8/7/2014 at 2:00 p.m., an interview with the Director of Nursing indicated when a resident had a fall, the careplan was to be updated. At that time, the DoN indicated Resident #35's fall careplan had not been updated.</p> <p>On 8/7/2014 at 11:40 a.m., the Administrator provided the INCIDENT MANAGEMENT POLICY, dated September 2011, and indicated the policy was the one currently used by the facility. The policy indicated: Purpose "To promptly acknowledge and manage facility incidents and accidents to ensure the medical needs of affected individuals are identified and addressed; to analyze contributing factors and environmental conditions that may be modified in order to provide a safe environment and reduce incidence of reoccurrence; to provide a process for tracking modified in order to provide a safe environment and reduce incidence of occurrence; to provide a process for tracking and trending incident data for improved quality of care..."</p> <p>3.1-35(d)(2)(B)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to ensure Resident #49 maintained optimal bladder function as the facility policy indicated for 1 of 2 residents reviewed for urinary incontinence. (Resident #49)</p> <p>Findings include:</p> <p>Resident #49's clinical record was reviewed on 8/8/2014 at 10:14 a.m. Diagnoses included, but were not limited to: osteoarthritis, diabetes mellitus, blindness, chronic ischemic heart disease, hypertension, hypothyroidism, dyspepsia, spinal stenosis, lumbago, and anxiety.</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 6/27/2014, assessed Resident #49 as frequently incontinent</p>	F000315	<p>Resident number 49 was reviewed immediately and re-assessed for a bowel and bladder program. Residents care plan was updated to reflect the resident's current status. All residents who are incontinent of bowel and bladder have the potential to be affected by this. Residents that are on a bowel and bladder program were reassessed to ensure accuracy of their current program and updates were made to their bowel and bladder program reflecting any changes made. The DON or designee will audit 5 residents with bowel and bladder programs and update their cared plans regarding any changes made weekly x 4 weeks, then 5 x monthly for 2 months, then 5 residents quarterly there after. The systematic changes will be completed by September 7, 2014.</p>	09/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of urine and no toileting program in place.</p> <p>On 8/8/2014 at 10:40 a.m., an interview with CNA #2 indicated Resident #49 is always continent during the day, but is always wet when they get her out of bed in the morning.</p> <p>On 8/8/2014 at 10:45 a.m., an interview with LPN #2 indicated Resident #49 is incontinent in the morning when the CNA's get her out of bed. At that time, she indicated Resident #49 is continent of bladder during the day and uses a brief for possible leakage of urine.</p> <p>On 8/8/2014 at 11:00 a.m., an interview with CNA #1 indicated Resident #49's bed is wet when they get her up in the morning. At that time, CNA #1 indicated Resident #49 was continent of bladder during the day and wears a brief in case of urine leakage.</p> <p>On 8/8/2014 at 10:30 a.m., the Administrator provided the careplan and Bowel &amp; Bladder Assessment and Management for Resident #49. The careplan titled "CONTINENCE CARE PLAN" initiated on 3/27/2014 and updated on June of 2014, indicated Resident #49 had "no urine incontinence, no B/B [bowel/bladder]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>Retraining/Individual Schedule, no Prompted Toileting or Scheduled T. [Toileting Plan], no Incontinence Mgmt. [Management] program." Interventions included but were not limited to:</p> <p>"Monitor and record bowel and bladder patterns each shift, regularly assess bowel and bladder status and management programs, report to MD [medical doctor] abnormal symptoms or conditions..."</p> <p>The "Bowel &amp;Bladder Assessment and Management" tool indicated on 6/27/2014, a score of 4, which indicated continent; No further intervention required.</p> <p>On 8/8/2014 at 11:05 a.m., LPN #2 provided the facilities "ACTIVITY OF DAILY LIVING Nurse Assistant Care Record" for Resident #49's bowel/bladder continence, and the computerized care plan titled "ADL [Activities of Daily Living]- Toileting."</p> <p>The ADL Nursing Assistant Care Record indicated:</p> <p>On day shift no charting from 8/1-8/5 2014. On 8/6/2014 continent and incontinent of bladder.</p> <p>On evening shift No charting on 8/1, 8/2, 8/4, 8/5, 8/6. On 8/3, 8/4, 8/7, 2014 continent and incontinent of bladder.</p> <p>On night shift No charting for 8/2, 8/4.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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			
F000329 SS=D	<p>On 8/1, 8/3, 8/5, 8/6, 8/7, 2014 incontinent of bladder.</p> <p>The "ADL Plan of Care-Toileting" for Resident #49 indicated the resident was continent of bladder. No scheduled urine program or bladder training program in place. It indicated Resident #49 does not wear briefs.</p> <p>On 8/8/2014 at 1:42 p.m., the Assistant Director of Nursing provided the Bladder Management (Retraining) Program, dated 2006, and indicated the policy was the one currently used by the facility. The policy indicated: "Purpose....To improve the morale of the resident. To restore the resident' dignity and respect. To restore optimum level of bladder function. Assessment Guidelines May include, but are not limited to:....Cause of incontinence. Type of incontinence..."</p> <p>3.1-41(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>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 interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications for 3 of 5 residents reviewed for unnecessary medication use, in that Resident #46 had received an antianxiety medication, Resident #13 and Resident #58 received an antidepressant and a pharmacy recommended gradual dose reduction (GDR) had not been implemented as indicated by facility policy. (Resident #13, Resident #46, Resident #58).</p> <p>Findings include:</p>	F000329	Resident number 46, 13, and 58 on current psychotropic medication regimen was reviewed for current GDR (gradual dose reductions) immediately and updated to reflect their current status. Resident's currently receiving psychotropic medications have the potential to be affected. Residents currently receiving psychotropic medications were reviewed and assessed for possible current GDR gradual dose reductions recommendations and updated to reflect their current status. Residents on psychotropic medication regimen will be reviewed biweekly for one month,	09/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>1). Resident #46's clinical record was reviewed on 08/05/2014 at 2:25 p.m. Diagnoses included, but were not limited to: depressive disorder, generalized anxiety and dementia.</p> <p>GDR (Gradual Dose Reduction) request form dated 11/21/13, initiated by the pharmacist and approved by the medical doctor indicated, decrease Resident #46's Klonopin (used to treat seizures and panic attacks) from 0.5 mg every night to 0.25 mg (milligram) by mouth every night for anxiety.</p> <p>GDR (Gradual Dose Reduction) request form dated 4/17/14 initiated by the pharmacist and approved by the medical doctor indicated, "...Please consider Reduction to Klonopin 0.125 mg qhs [every night]... Yes, this Resident is a Candidate for a Dose Reduction [Refer to Physician's Orders]."</p> <p>Physicians order dated 4/18/14 indicated, "clonazepam [Klonopin] 0.5 mg tablet give 0.5 tablet [0.25 mg] by oral route once daily at bedtime half tab = 0.25 mg. ..." There was no GDR attempted for Resident #46's Klonopin since 11/21/13.</p> <p>Nursing notes dated 4/18/14 indicated, "N.O. [new order] Klonopin 0.125 PO</p>		<p>monthly for 3 months and then follow gradual dose reduction recommendations there after. (attachment D) Results of the audits will be reviewed in our QA process with a subsequent plan to be developed as necessary . The systematic changes will be completed by September 7, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>[by mouth] QHS [every hour of sleep] for a dose reduction. ... Pharmacy unable to provide 0.125 mg Klonopin. ... N.O. to D/C [discontinue] order for Klonopin 0.125 mg ... and restart Klonopin 0.25 mg ... 4/19/14. ..."</p> <p>Nursing notes dated 4/19/14 indicated, " ... pharmacy unable to provide Klonopin 0.125 mg so dose will remain @ (at) 0.25 mg as before. ..."</p> <p>On 8/7/14 at 11:40 a.m., interview with the Social Service and DON (Director of Nursing) present indicated when asked for clarification of Resident #46's GDR for Klonopin. "Our Pharmacist said 0.125 mg of the Klonopin was not available and the doctor said go back to 0.25 mg."</p> <p>On 8/8/14 at 1:45 p.m., interview with the Executive Director indicated, when asked what is the policy for when residents medication is unavailable? "We are to call our pharmacy and they have 4 hours to get the medication to us. If they don't have the medication they contact our stand by pharmacy."</p> <p>On 8/8/14 at 1:58 p.m., interview with the DON indicated, "I guess we don't have a policy for when medication is unavailable, but what we do is contact</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>our pharmacy and if not available we pull it from the EDK until we get it."</p> <p>2). Resident #58's clinical record was reviewed on 8/6/14 at 1:31 p.m. Diagnoses included, but not limited to: chronic kidney disease, congestive heart failure, diabetes, osteoarthritis, depressive disorder, anxiety, generalized pain and esophageal reflux.</p> <p>Physician's order dated 10/26/2013, indicated "Cymbalta 30 mg capsule, delayed release ... give 1 capsule [30mg] by oral route once daily."</p> <p>Care plan titled "DEPRESSION CARE PLAN" dated 6/21014, indicated "Problem ...Pain ... Other chronic pain ...Evidenced by: Negativity, Anger with self/others, irritability, ...Attention seeking, ... Intervention, provide encouragement [encouragement], support and reassurance for participation in decision making and activities, ...Establish daily routine based on residents input, Psych services as ordered, ... pain management, Monitor for significant side effects of anti-depressant medications and notify MD. ...Cymbalta, ..."</p> <p>Careplan dated 7/15/14, indicated " The resident uses antidepressant medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>Cymbalta r/t [related to] Depression ... Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q [every] shift. ..."</p> <p>On 8/6/14 at 3:30 p.m., interview with the Social Service worker indicated, when asked for Resident #58 Cymbalta GDR (Gradual Dose Reduction), " They don't have one [referring to a GDR] because they take Cymbalta for chronic pain."</p> <p>On 8/6/14 at 3:45 p.m. interview with the Social Service worker indicated, " [Name of Regional Director of Clinical Operations] told me that since Cymbalta is labeled for fibromyalgia, and musculoskeletal pain, osteoarthritis we don't have to do GDR's on it. Although it is a psychotropic drug its used to treat diabetic neuropathy."</p> <p>3). Resident #13's clinical record was reviewed on 8/5/14 at 3:27 p.m. Diagnoses included, but were not limited to: rheumatoid arthritis, anxiety, depressive, chronic pain, neurogenic bladder, and esophageal reflux.</p> <p>The Initial psychiatric evaluation dated 11/11/11, indicated Cymbalta for Resident #13's depression.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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 8/8/14 at 9:33 a.m., interview with LPN #3 indicated when asked what is Resident #13 receiving for pain, " She gets oxycodone and she gets a Fentanyl patch." When asked what does Resident #13 takes Cymbalta for? LPN#3 indicated, "Depression."</p> <p>Review of August 2014 physician recapulation orders indicated "8/11/12" (start date) "duloxetine [Cymbalta] 60 mg capsule ... give 1 capsule ...once daily ... depressive disorder, ..."</p> <p>Review of careplan dated 5/2014 indicated, "DEPRESSION CAREPLAN ...Problem Actual/Risk of Depression R/T: (related to) Pain, ...chronic pain, ...evidenced by ...Anger with self/others, irritability, ...Attention seeking, Refusal of care, ... Intervention... Encourage positive coping mechanisms, Praise positive efforts, Encourage adequate rest, relaxation, nutrition and exercise, Encourage to participate in social activities of interest, ...Encourage to express feelings of anger, guilt or frustration, ...Psych services as ordered, ... pain management, ... Monitor for significant side effects of anti-depressant medications and notify MD:... Cymbalta, ..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>There was no GDR done for Resident #13's Cymbalta. Resident # 13 has been on Cymbalta since 12/15/11.</p> <p>On 8/6/14 at 3:30 p.m., interview with the Social Service worker indicated, when asked for Resident #13 Cymbalta GDR (Gradual Dose Reduction), indicated, "They don't have one [referring to a GDR] because they take Cymbalta for chronic pain."</p> <p>On 8/6/14 at 3:49 p.m., the Social Service worker provided a printout from "Clinical Pharmacology" and indicated that this was the guidelines they follow. The printout indicated, " Duloxetine [Cymbalta] Indications: Labeled depression, diabetic neuropathy, fibromyalgia, ... musculoskeletal pain, osteoarthritis, ... For treatment of major depression, ... For the treatment of pain associated with diabetic neuropathy, ... For the treatment of pain associated with fibromyalgia, ... For the treatment of chronic musculoskeletal pain, ..."</p> <p>On 8/5/14 at 1:59 p.m., the Executive Director provided the policy "Psychoactive Medication Management" dated 2008, and indicated that was the one currently used by the facility. The policy indicated, " ... It is the policy of this facility that residents in need of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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
F000441 SS=E	<p>psychotherapeutic medications ... that medications are evaluated regularly and opportunities for reduction are identified and attempted as appropriate, when determined by the IDT and/or resident's physician. ... 3. When psychoactive medications are prescribed for a specific condition ... the clinical record will be reflective of the diagnosis, reasons for use ... 10. Residents receiving ... anti-anxiety, anti-depressant ... should be evaluated no less often than Quarterly for on-going clinical appropriateness and consideration of a gradual dose reduction attempt."</p> <p>3.1-48(b)(2)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed as the facility policy and the CDC (Centers for Disease Control) indicated in that, a nurse while doing a dressing change did not wash her hands for 20 seconds and did not change her gloves for 1 of 1 residents randomly observed during a dressing change. (Resident #76, LPN #1).</p>	F000441	Resident number 13 and 76 involved in the alleged deficient practice was not negatively affected by the practice. Staff were in-serviced on handwashing procedures and clean dressing change procedures. The DON or designee will do hand washing and wound care audits 5 weekly on all shifts including weekends for 1 month then 5 monthly and then 5 quarterly to verify current accurate facility procedures are being followed. (See attachment	09/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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>B). Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing and glove change during personal care as indicated by the Center for Disease Control for 1 of 1 randomly observed resident for personal care. (Resident #13)(CNA #3, CNA #4, CNA #5, QMA #1)</p> <p>Findings include:</p> <p>A. On 8/8/2014 at 2:00 p.m., an observation of a dressing change to Resident #76's right foot completed by LPN #1. LPN #1 washed her hands for 10 seconds and donned (applied) gloves. The trash bag was on the floor, LPN #1 picked the bag up off the floor and placed it on the bed to use for trash. LPN #1 removed dressing and cleansed wound. Washed hands for 10 seconds and donned gloves. After reapplying the dressing, LPN #1 touched the pillow to reposition the resident's leg and rearranged the residents sheet to cover Resident #76's leg, without changing gloves or hand sanitizing. LPN #1 then washed her hands for 8 seconds.</p> <p>On 8/8/2014 at 2:15 p.m., an interview with LPN #1 indicated the proper amount of time for hand washing was 15 seconds.</p>		E) The systemic changes will be completed by September 7, 2014.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2014	
NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460			
(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>At that time, LPN #1 indicated she sang the Yankee Doodle Dandy Song to ensure she had handwashed long enough.</p> <p>Review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands?" indicated: "...Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the 'Happy Birthday' song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them ..."</p> <p>On 8/5/2014 at 1:54 p.m., the Administrator provided the INFECTION CONTROL GUIDELINES, dated 2006, and indicated it was the policy currently used by the facility. The policy indicated: "...Maintain sterility or cleanliness of the equipment and working field as necessary..."</p> <p>On 8/9/2014 at 2:30 p.m., the Director of Nursing provided Dressing Change,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>Clean, dated 2006, and indicated it was the policy currently used by the facility. The policy indicated: Purpose "... to prevent infection and spread of infection..."</p> <p>12. Apply dressings and secure with tape 13. Remove gloves and discard with all unused supplies in plastic bag. 14. Assist resident to comfortable position with call light in reach." B). Resident #13's clinical record was reviewed on 8/6/14 at 3:10 p.m. Diagnoses included, but were not limited to: rheumatoid arthritis, anxiety, depressive, chronic pain, neurogenic bladder, and esophageal reflux.</p> <p>On 8/4/14 at 2:31 p.m., observed QMA (Qualified Medical Assistant) #1, CNA (Certified Nursing Assistant) #3, and CNA #4 to enter Resident #13's room to place Resident #13 in the bed with a mechanical lift and provide personal care. The 3 staff members placed on gloves. No handwashing was observed.</p> <p>At 2:30 p.m., QMA #1 was observed to remove gloves and handwash for 10 seconds, then exit the room to get medication for Resident #13.</p> <p>At 2:34 p.m., CNA #5 was observed to enter Resident #13's room handwashed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(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>for 10 seconds, place on gloves, walked over to the bed and placed the mechanical lift sling in a plastic bag, removed gloves and walked into the bathroom to look for a pillow. CNA #5 exited the bathroom and left the room with the plastic bag that contained dirty linen. No handwashing was observed.</p> <p>At 2:37 p.m., QMA #1 entered the room with pain medication for Resident #13. No handwashing was observed. QMA #1 gave Resident #13 the pill, entered the bathroom, handwashed for 7 seconds, and exited the room.</p> <p>At 2:40 p.m., CNA #3 was observed to empty urine from Resident #13's catheter, removed gloved and handwashed for 12 seconds.</p> <p>At 2:41 p.m., CNA #4 was observed to remove gloves, entered the bathroom and handwashed for 8 seconds. CNA #4 removed the mechanical lift from Resident #13's room. CNA #4 entered the room with a pillow, placed the pillow under Resident #13's left leg, entered the bathroom, and handwashed for 7 seconds.</p> <p>At 2:44 p.m. interview with CNA #3 and CNA #4 indicated, when asked when should you handwash? CNA #3</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated, "Before and after each resident, after serving 3 trays, in between residents." When asked was that done. CNA #3 indicated, "No." When asked how long should you handwash? CNA #4 indicated, "Two minutes." CNA #3 indicated, "1 minute." When asked was that done, both CNA's indicated, "No."</p> <p>On 8/11/14 review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands?" indicated "...Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the 'Happy Birthday' song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them"</p> <p>3.1-18(l)</p>			