

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 26, 27, 28, and 29, 2011</p> <p>Facility number: 000021 Provider number: 155710 AIM number: 100275270</p> <p>Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 79 Total: 82</p> <p>Census payor type: Medicare: 4 Medicaid: 65 Other: 13 Total: 82</p> <p>Sample: 17</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/05/11 by Suzanne</p>	F0000	<p><u>Disclaimer</u></p> <p>Chase Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. Chase Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position, and Chase Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Chase Center does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Chase Center offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.</p> <p>Chase Center reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.</p>		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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
F0250 SS=D	<p>Williams, RN</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure medically-related social services were provided and the psychosocial aspects of a resident's condition was addressed completely, for 1 of 2 residents with a terminal diagnosis reviewed in a sample of 17. (Resident #6)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 09/26/11 from 11:00 A.M. - 11:35 A.M., LPN #9, the unit manager, indicated Resident #6 was a newer admission with terminal cancer. She indicated the resident had family that visit but did not have hospice care due to an insurance issue. She indicated the facility had really worked to adjust the resident's pain and anxiety medications in an effort to make Resident #6 comfortable.</p> <p>On 09/27/11 from approximately 9:00 A.M. - 11:00 A.M., Resident #6 was observed in his room in his bed. The resident was noted to alternate between</p>	F0250	<p>F 250</p> <p><u>Corrective action(s) for those identified:</u></p> <p>For Resident #6, on 9/28/11, the plan of care was updated to address the resident's anxiety and grief related to his terminal diagnosis. Since that date, the care plan team has further reviewed and updated the resident's plan of care, as needed, as related to the terminal condition, including approaches for periodically offering support options, such as hospice services, pastoral care, and community mental health services. At the care plan meeting on 10/19/11, the options for hospice services and pastoral care were presented and declined by the family. The resident has previously declined pastoral care, as documented by the Social Services Director. The Social Services Director has documented and will continue to document the results of the resident/family response to hospice and other grief/anxiety support options.</p> <p>- <u>Identification of others potentially affected:</u></p>	10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>resting, watching television, and then would bang on his overbed table, clear his throat, sit up frequently in his bed, and motion anyone in the hallway to come to his room. The resident would especially become restless after a timer, noted to be hanging at the nurse's station, would sound. Interview at 10:40 a.m. with LPN #9 indicated the timer was there to help alleviate Resident #6's anxiety related to pain issues. The timer was set to alert the resident when he could have more pain medication. LPN #9 was noted to frequently get up from the nurse's station and go to Resident #6's room to attend to his frequent needs. At one point Resident #6 indicated he could not breath and a respiratory treatment was offered by LPN #9.</p> <p>The clinical record for Resident #6 was reviewed on 09/27/11 at 10:18 A.M. Resident #6 was admitted to the facility on 08/28/11 with diagnoses including, but not limited to, terminal throat cancer. The initial Minimum Data Set (MDS) assessment had been completed for Resident #6 on 09/12/11. The current health care plans for Resident #6, initiated from 08/31/11 - 09/12/11, indicated there was no plan to address the psychosocial aspects of the resident's terminal prognosis or the resident's anxiety. There was a plan to address the resident's</p>		<p>The Social Services Director and/or other care plan team member will review the medical record of all residents and, for those residents identified with a terminal diagnosis, will write or update the plan of care, as needed, to address potential or actual grief or anxiety related to the terminal diagnosis. Interventions might include offering hospice services, pastoral or religious care, and community mental health services.</p> <p><u>Measures to prevent recurrence:</u> For each resident admitted with a terminal diagnosis, and for each resident who acquires a terminal diagnosis during residency, the Social Services Director or other care plan team member will write the plan of care, as needed, to address potential or actual grief or anxiety related to the terminal diagnosis. For each resident currently with a terminal diagnosis, the care plan team will update the plan of care, as needed. At each care plan meeting, at least quarterly, the care plan team will review these plans of care, in order to ensure that each resident's needs are addressed in relation to grief or anxiety. Interventions might include offering hospice services, pastoral or religious care, and community mental health services. The Social Services Director maintains a list of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>advance directive - no code - status with interventions to monitor the resident for complaints of pain or discomfort, to provide comfort interventions, notify the physician and family as needed, and not to initiate CPR (cardio-pulmonary resuscitation) procedure.</p> <p>Review of a History and Physical report from an acute care facility, indicated the resident had experienced a cardiac issue, in addition to his cancer issues, and had been unresponsive. The report indicated when the resident regained consciousness he was fearful and verbalized "I don't want to die."</p> <p>Review of the physician orders from admission indicated the resident's anti-anxiety medication, Ativan, orders had been increased four different times since the resident was admitted to the facility. In addition, the resident's orders for potential frequency of breathing treatments had been increased from every 6 hours to every 2 hours as needed. The resident's pain medications orders had also been adjusted and increased.</p> <p>Review of the nursing notes and medication administration records for September 2011 indicated the resident required as needed anxiety medication, in addition to the routinely administered</p>		<p>community resources that provide support for residents with grief or anxiety issues related to a terminal condition.</p> <p><u>Monitoring:</u> At each scheduled care plan meeting, the Care Plan Coordinator or designee will ensure that the plan of care is reviewed and updated as needed and appropriate to address the needs of every resident with a terminal diagnosis, specifically symptoms related to grief or anxiety.</p> <p>At each meeting of the Quality Assurance (QA) sub-committee (twice monthly), the Care Plan Coordinator or designee will submit a report indicating that, at the scheduled care plan meetings, the care plan team reviewed and appropriately updated the plan of care for each resident with a terminal diagnosis. The QA sub-committee will review these reports and make appropriate recommendations or take appropriate actions to ensure that the plan of care is appropriately updated for each resident with a terminal diagnosis.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>anxiety medications, on 09/02/11, 09/07/11, twice on 09/08/11, 09/09/11, three times on 09/03/11, twice on 09/12/11, twice on 09/13/11, twice on 09/14/11, three times on 09/15/11, 09/16/11, 09/17/11, 09/18/11, twice on 09/19/11, 09/20/11, 09/22/11, 09/23/11, and 09/25/11. The electronic nursing charting indicated the resident was exhibiting the following on each occasion: "anxiety, restlessness, nervous verbalizations such as 'I feel so nervous' or 'My insides are shaking,' inability to complete tasks, inability to sit still for any length of time."</p> <p>Review of the social service notes, from admission to 09/27/11, indicated social service completed an admission note, dated 09/01/11 at 3:33 P.M. indicating the resident's age, diagnosis, mode of transportation to the facility, orientation to the physician, information regarding resident rights and advance directives, visiting hours, condition of the resident's speech, medication for ativan (an antianxiety medication) and ambien (a medication for sleep), no indication of any behavioral issues, and the resident's family support and name of his daughter who was his POA/HCR (Power of Attorney and Health Care Representative). The note did not mention any discussion regarding the</p>		recurrence of each "deficient practice" and the steps for monitoring are carried out as described.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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>possibility of utilizing Hospice services, nor any discussion involving spiritual needs related to the resident's condition.</p> <p>A social service note, dated 09/11/11, indicated the social service director had visited with the resident and he was in a "pleasant mood." The note indicated hearing aide purchase assistance was offered to the resident but he declined. The note also indicated the resident had not exhibited any behavioral concerns, took Ambien for insomnia and Ativan for anxiety, and based on a mood assessment, displayed minimal depressive symptoms, and had good family support.</p> <p>The next social service note, dated 09/12/11 was an electronic assessment of any symptoms regarding mood issues. The resident indicated he had little energy or pain during the past 14 days. The assessment asked the resident about appetite and overeating even though the resident had a gastrostomy tube and did not eat anything by mouth.</p> <p>A late entry, completed on 09/27/11 after a request for a copy of social service notes was made, indicated on 09/20/11 a visit was made by social service after receiving reports on 09/17/11, 09/18/11, and 09/19/11 of increased confusion and anxiety. The note indicated the resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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>displayed anxious behaviors, constantly moving, picking up remote and pushing buttons on keyboard. The resident was also noted to have increased confusion. The resident could not think of anything the social services could do to make him more comfortable, indicated he had just had pain medication, and refused offers of a back rub or walk. The resident was reassured of staff's presence outside of his room if he needed them.</p> <p>Interview with the Social Service Director, Employee #12, on 09/28/11 at 9:15 A.M., indicated she did not know if hospice had been addressed with the resident. She indicated the resident had private insurance that has to be pre-approved every 7 days. The social service director also indicated she did not know if pastoral care or any potential spiritual issues had been discussed or offered to the resident. She indicated she did not know why anxiety and grief over terminal diagnosis had not been care planned for Resident #6.</p> <p>Interview with the Admission Coordinator, employee #13, on 09/28/11 at 10:00 A.M., indicated the resident's family had chosen to utilize all of his eligibility with his private insurance, which did not allow for Hospice services before they applied for Medicaid and then</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	
F0279 SS=D	<p>might consider Hospice service. She indicated the resident's family "did not act too concerned (about Hospice)."</p> <p>On 09/28/11 at 10:55 A.M., the resident's physician was overheard discussing Hospice services with the resident. The physician informed the resident Hospice provided care to the dying but would basically provide the same care as the facility's nursing staff. The resident declined Hospice services.</p> <p>3.1-34(a)</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to ensure 2 of 5 residents reviewed for behaviors in a</p>	F0279	F 279 NOTE: The surveyor noted that the CARE PLANNING policy was dated 6/1/01. However, this	10/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>sample of 17 had care plans to address anxiety (Residents #6 and 31). In addition, 1 of 2 residents reviewed for social service needs in a sample of 17 had a care plan to address the potential psychosocial needs related to a terminal condition. (Resident #6)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 09/26/11 from 11:00 A.M. - 11:35 A.M., LPN #9, the unit manager, indicated Resident #6 was a newer admission with terminal cancer. She indicated the resident had family that visit but did not have hospice care due to an insurance issues. She indicated the facility had really worked to adjust the resident's pain and anxiety medications in an effort to make Resident #6 comfortable.</p> <p>On 09/27/11 from approximately 9:00 A.M. - 11:00 A.M., Resident #6 was observed in his room in his bed. The resident was noted to alternate between resting, watching television, and then would bang on his overbed table, clear his throat, sit up frequently in his bed, and motion anyone in the hallway to come to his room. The resident would especially become restless after a timer, noted to be hanging at the nurse's station would</p>		<p>is a reference to the original date of the policy, located in the footer of each page in the policy. As indicated at the end of the policy, this policy had been updated on 10/26/07 and 6/28/11. <u>Corrective action(s) for those identified:</u> For Resident #6, on 9/28/11, the plan of care was updated to address the resident's anxiety and grief related to his terminal diagnosis. The care plan team will review and update, as needed, the resident's plan of care for anxiety and grief issues at the next care plan meeting. For Resident #31, on 9/28/11, the plan of care was updated to address the resident's potential for anxiety. The care plan team will review and update, as needed, the resident's plan of care for potential anxiety at the next care plan meeting. <u>Identification of others potentially affected:</u> The Social Services Director and/or other care plan team member will review the medical record of all residents and, for those residents identified with a terminal diagnosis or potential/actual anxiety issues, will write or update the plan of care, as needed, to address grief or anxiety. <u>Measures to prevent recurrence:</u> The Care Plan Coordinator has provided in-service training to the interdisciplinary team regarding how to write plans of care for residents in need of support for grief or anxiety issues related to a terminal condition. For each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>sound. Interview at 10:40 a.m. with LPN #9 indicated the timer was there to help alleviate Resident #6's anxiety related to pain issues. The timer was set to alert the resident when he could have more pain medication. LPN #9 was noted to frequently get up from the nurse's station and go to Resident #6's room to attend to his frequent needs. At one point Resident #6 indicated he could not breath and a respiratory treatment was offered by LPN #9.</p> <p>The clinical record for Resident #6 was reviewed on 09/27/11 at 10:18 A.M. Resident #6 was admitted to the facility on 08/28/11 with diagnosis, including but not limited to terminal throat cancer. The initial Minimum Data Set (MDS) assessment had been completed for Resident #6 on 09/12/11. The current health care plans for Resident #6, initiated from 08/31/11 - 09/12/11 indicated there was no plan to address the psychosocial aspects of the resident's terminal prognosis or the resident's anxiety. There was a plan to address the resident's advance directive - no code - status with interventions to monitor the resident for complaints of pain or discomfort, to provide comfort interventions. Notify the physician and family as needed, and not to initiated CPR (cardio-pulmonary necessitation) procedure.</p>		<p>resident admitted with a terminal diagnosis, and for each resident who acquires a terminal diagnosis during residency, the Social Services Director or other care plan team member will write the plan of care, as needed, to address potential or actual grief or anxiety related to the terminal diagnosis. For each resident currently with a terminal diagnosis, the care plan team will update the plan of care, as needed. At each subsequent care plan meeting, the care plan team will these plans of care, in order to ensure that each resident's needs are addressed in relation to grief or anxiety. For each resident who is admitted with anxiety issues, and for each resident with a new physician order for anti-anxiety medication, the Social Services Director or other care plan team member will write the plan of care, as needed, to address the potential or actual anxiety. For each resident with ongoing anxiety issues, or who currently receives an anti-anxiety medication, the care plan team will update the plan of care, as needed. At each subsequent care plan meeting, the care plan team will review these plans of care, in order to ensure that the resident's needs are addressed in relation to anxiety. <u>Monitoring:</u> At each scheduled care plan meeting, the Care Plan Coordinator or designee will ensure that the plan of care is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>Review of a History and Physical report, dated _____, from an acute care facility, indicated the resident had experienced a cardiac issue, in addition to his cancer issues, and had been unresponsive. The report indicated when the resident regained consciousness he was fearful and verbalized "I don't want to die."</p> <p>Review of the physician orders from admission indicated the resident's anti-anxiety medication, Ativan, orders had been increased 4 different times since the resident was admitted to the facility. In addition, the resident's orders for potential frequency of breathing treatments had been increased from every 6 hours to every 2 hours as needed. The resident's pain medications orders had also been adjusted and increased.</p> <p>Review of the nursing notes and medication administration records for September 2011 indicated the resident required as needed anxiety medication, in addition to the routinely administered anxiety medications on 09/02/11, 09/07/11, twice on 09/08/11, 09/09/11, three times on 09/03/11, twice on 09/12/11, twice on 09/13/11, twice on 09/14/11, three times on 09/15/11, 09/16/11, 09/17/11, 09/18/11, twice on 09/19/11, 09/20/11, 09/22/11, 09/23/11,</p>		<p>reviewed and updated as needed and appropriate to address the needs of every resident with a terminal diagnosis and/or potential or actual anxiety issues.</p> <p>At each meeting of the Quality Assurance (QA) sub-committee (twice monthly), the Care Plan Coordinator or designee will submit a report indicating that, at the scheduled care plan meetings, the care plan team reviewed and appropriately updated the plan of care for each resident with a terminal diagnosis and/or anxiety issues. The QA sub-committee will review these reports and make appropriate recommendations or take appropriate actions to ensure that the plan of care is appropriately updated for each resident with a terminal diagnosis and/or anxiety issues. At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and 09/25/11. The electronic nursing charting indicated the resident was exhibiting the following on each occasion: "anxiety, restlessness, nervous verbalizations such as 'I feel so nervous' or 'My insides are shaking' inability to complete tasks, inability to sit still for any length of time."</p> <p>Interview with the Social service director, on 09/28/11 at 9:16 A.M., indicated she did not know why anxiety and grief over terminal diagnosis had not been care planned for Resident #6.</p> <p>2. Resident #31's record was reviewed on 9/28/11 at 10:10 a.m. Resident #31's diagnoses included, but were not limited to, anxiety, Parkinson's disease, and dementia.</p> <p>Resident #31 was noted to have an order for an antianxiety medication on the current September physician's order summary dated 9/13/2011. The medication was ordered to be given routinely twice daily.</p> <p>A review of behavior and mood notes for September 2011 indicated Resident #31 had no signs of anxiety in the last 30 days.</p> <p>In an interview on 9/28/2011 at 11:10 a.m. the Social Services Director indicated because he was showing no</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	
F0282 SS=D	<p>anxious behavior, because the antianxiety medication was effective, there had been no care plan initiated to inform or guide staff should Resident #31 have any anxious episodes. She further indicated a care plan should have been initiated.</p> <p>A current policy, titled Care Planning, dated 6/1/01 indicated all problems must be care planned including individualized nursing measures to be carried out.</p> <p>3.1-35(a)</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 record review and interview, the facility failed to follow health care plans to prevent falls for 2 of 8 residents (#40, 67) reviewed for falls in a sample of 17.</p> <p>Findings include:</p> <p>1. Resident #67's clinical record was reviewed on 9/26/11 at 1:10 P.M.. The record indicated the resident had a history of falls. The resident had a health care plan of 11/1/10 indicating a potential for injury related to trauma/falls due to poor balance and required a two person assist with a gait belt for all transfers.</p>	F0282	<p>F 282 <u>Corrective action(s) for those identified:</u> For Resident #67, on 8/12/11, CNA #4 was re-educated in regard to following the plans of care for residents in regard to safety techniques for transfers. For Resident #40, on 10/13/11 and 10/14/11, nursing staff received re-education in regard to placing residents in the correct wheelchairs, as labeled with the residents' names. <u>Identification of others potentially affected:</u> On the headboard of each resident's bed, a label has been placed, indicating, by means of a code, the safety technique to be utilized for transferring that resident, as identified in each resident's plan of care. The code indicates the</p>	10/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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 8/11/11 at 9:35 A.M. resident #67 was "lowered to floor while trying transfer into bed" by Certified Nursing Assistant (CNA) #4. The resident had no apparent injury and no complaints of pain.</p> <p>A fall investigation report by the facility indicated CNA #4 did not follow through on safety techniques for transfers of residents requiring two staff assist with a gait belt.</p>		<p>number of staff needed for safe transfer with gait belt or other equipment, such as sit-to-stand lift or other mechanical lift.. See "Resident Handling Policy: LIMITED LIFT" (Exhibit A). On 10/13/11 and 10/14/11, nursing staff received retraining on the meaning of this code system that indicates transfer technique. On those dates, nursing staff also received retraining on the mandatory use of the wheelchair appropriate for each resident, as identified by nursing managers or therapy staff. <u>Measures to prevent recurrence:</u> On the headboard of each resident's bed, a label has been placed, indicating, by means of a code, the safety technique to be utilized for transferring that resident, as identified in each resident's plan of care. The code indicates the number of staff needed for safe transfer with gait belt or other equipment, such as sit-to-stand lift or other mechanical lift.. See "Resident Handling Policy: LIMITED LIFT" (Exhibit A). On 10/13/11 and 10/14/11, nursing staff received retraining on the meaning of this code system that indicates transfer technique. On those dates, nursing staff also received retraining on the mandatory use of the wheelchair appropriate for each resident, as identified by nursing managers or therapy staff. Through the use of newly redesigned CNA assignment sheets (Exhibit B),</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	
			generated directly from the care plan in the Electronic Charting System, nursing staff will be informed of each resident's plan of care for transfers and any changes in that plan. The CNA assignment sheets will be available to CNAs in a plastic protector sheet on the back of each resident's headboard. Daily, Monday through Friday on the day shift, each nursing unit manager or designee will observe one resident during transfer, in order to determine whether safety technique is being used per plan of care, as well as whether the appropriate wheelchair, if needed, is being used for the resident. Each unit manager will take appropriate corrective action, in the event that incorrect transfer technique or inappropriate wheelchair is utilized. On the evening shift, this same observation (of transfer technique and wheelchair usage, if used) and corrective action will be performed by the evening nurse supervisor. On Saturday and Sunday, the same observation (of transfer technique and wheelchair usage, if used) and corrective action will be performed daily by the designated weekend manager. <u>Monitoring:</u> The nursing unit managers, the evening supervisor, and the weekend manager will report their daily observations and corrective actions to the Director of Nursing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>2. Resident #40's record was reviewed 9/28/2011 at 1:15 p.m. Resident #40's diagnoses included but were not limited to diabetes, peripheral neuropathy (pain and numbness in legs and feet), and dementia.</p> <p>Resident #40's fall care plan dated 9/28/2009 and updated 6/9/2011 indicated under interventions to use safety devices needed. The care plan interventions had been updated 6/8/2011 to include place resident in assigned wheelchair for safety.</p>		<p>The Director of Nursing will provide a summary report of observations and corrective actions to the QA sub-committee. The QA sub-committee will review the reports of the Director of Nursing and make any further recommendations or take any further actions deemed necessary to ensure that residents are transferred with safe technique and that the designated wheelchair is utilized for each resident. At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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>Nurse's notes dated 6/8/2011 indicated Resident #40 fell from his wheelchair.</p> <p>Fall investigation dated 6/8/2011 indicated Resident #40 fell from his wheelchair because he was in a wheelchair not fitted to him by therapy. The intervention was to assure Resident #40 was in the wheelchair fitted to him by therapy.</p> <p>In an interview on 9/29/2011 at 9:29 a.m. LPN #1 indicated therapy did extensive positioning with wheelchair residents so propelling and skin breakdown were not issues. Additionally, each resident had their names on their chairs to assure each resident was in the correct chair to prevent falls. She further indicated staff were educated regarding this system on hire and during job specific orientation. She further indicated staff placing the resident in the incorrect chair the day of the fall on 6/8/2011 was a staff member that had been employed by the facility for some time and knew to put residents in their chairs fitted to them.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER CHASE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947			
(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			
F0315 SS=E	<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 observation, record review, and interview, the facility failed to ensure incontinence was thoroughly assessed and care plans regarding urinary incontinence were individualized and followed, for 4 of 8 residents reviewed for incontinence in a sample of 17. (Resident #10, 40, 67, and 79.)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 09/26/11 from 11:00 A.M. - 11:35 A.M., LPN #9 indicated Resident #10 was confused, had experienced a recent urinary tract infection, was incontinent of her bladder, and was toileted by staff. She indicated the resident had also fallen recently related to her urinary tract infection.</p> <p>The clinical record for Resident #10 was reviewed on 09/28/11 at 9:30 A.M. Resident #10 was admitted to the facility on 05/29/11 with diagnoses including, but</p>	F0315	<p>F 315 <u>Corrective action(s) for those identified:</u> The urinary continence of Residents #10, #40, #67, and #79 will be assessed, including use of the "Bowel & Bladder Flow Sheet" (Exhibit C), which provides voiding pattern results. The nursing unit manager will include a summary of the voiding pattern results in the bladder assessment, which will become the basis for the care plan team initiating or updating these residents' individualized plan of care for urinary incontinence.</p> <p><u>Identification of others potentially affected:</u> The nursing unit managers or designee will audit the plans of care for all residents, in order to identify residents with need for a toileting plan to address urinary incontinence. For those residents with need for a toileting plan, the nursing unit managers or Restorative Nurse will initiate or update the plan of care to address urinary incontinence. Through the use of newly</p>	10/31/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>not limited to, diabetes, obesity, mixed incontinence, and a recent mastectomy due to breast cancer.</p> <p>Review of the initial Minimum Data Set (MDS) assessment for Resident #10, completed on 06/06/11, indicated the resident was frequently incontinent of her bladder. The most recent quarterly review of the MDS assessment, completed on 08/31/11, indicated the resident had declined and was now always incontinent of her bladder.</p> <p>Review of a five day voiding pattern form, completed from 05/29/11 - 06/02/11, indicated the resident had been documented as having incontinent episodes 5 times in the 5 day time frame. Two of the 5 times had been at 11:00 A.M., and 2 of the 5 times had been at 3 - 4 A.M. The final summary only indicated "Incontinent of bladder."</p> <p>Review of the current health care plan for Resident #10 regarding bladder incontinence, initiated on 06/06/11 and indicated as current, indicated the resident was to be assessed for urinary tract infections, encouraged to drink fluids, pericare was to be provided when the resident was incontinent, and the resident was to wear incontinence briefs, and any changes in the resident's voiding pattern</p>		<p>redesigned CNA assignment sheets (Exhibit B), generated directly from the care plan in the Electronic Charting System, nursing staff will be informed of each resident's urinary plan of care and any changes in that plan. The CNA assignment sheets will be available to CNAs in a plastic protector sheet on the back of each resident's headboard.</p> <p><u>Measures to prevent recurrence:</u> Upon admission, with a significant change in a resident's bladder function, and with each annual or significant change Minimum Data Set (MDS) assessment, the urinary continence of will be assessed, including use of the "Bowel & Bladder Flow Sheet" (Exhibit C), which provides voiding pattern results. The nursing unit manager will include a summary of the voiding pattern results in the bladder assessment. (Bladder assessments are also completed by the nursing unit manager with each resident's quarterly MDS assessment.) The bladder assessment will become the basis for the care plan team initiating or updating these residents' individualized plan of care for urinary incontinence. Through the use of newly redesigned CNA assignment sheets (see example, Exhibit B), generated directly from the care plan in the Electronic Charting</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>or appearance of urine was to be reported to the nurse. There was only a restorative toileting plan to address the resident's bowel needs.</p> <p>Interview with CNA #10, on 09/29/11 at 11:00 A.M., indicated Resident #10 had usually been able to tell staff she needed to be toileted but was not always verbalizing the need in time to prevent incontinence. She also indicated the resident was toileted "every couple hours."</p> <p>Interview with LPN #11, on 9/29/2011 at 10:00 a.m., indicated recently the resident had a urinary tract infection and some increased confusion and had not been as continent or had not been telling staff she needed to urinate as often.</p> <p>A physician's order dated 8/16/2011 indicated Resident #10 was ordered an antibiotic for her urinary tract infection.</p> <p>Interview with LPN #9, on 09/29/11 at 10:00 A.M., indicated the resident was being sent to the acute care center for decreased level of consciousness. LPN #9 also indicated a 5 day voiding pattern had not been completed in August 2011 as they were only completed on admission, when a catheter was removed, or with a significant change of condition.</p>		<p>System, nursing staff will be informed of each resident's urinary plan of care and any changes in that plan. The CNA assignment sheets will be available to CNAs in a plastic protector sheet on the back of each resident's headboard.</p> <p>Daily, Monday through Friday on the day shift, each nursing unit manager or designee will observe at least one resident with toileting needs, in order to determine whether needs are being met according to the plan of care. Each unit manager will take appropriate corrective action, in the event that the resident's toileting needs are not being met according to the plan of care. On the evening shift, this same observation and corrective action will be performed by the evening nurse supervisor. On Saturday and Sunday, the same observation and corrective action will be performed daily by the designated weekend manager.</p> <p><u>Monitoring:</u> At each meeting of the QA sub-committee (twice monthly), the nursing unit managers will provide a summary report that identifies how many residents' plans of care for urinary needs were initiated or updated, the results of observations of staff regarding toileting schedules, and actions taken to address areas of improvement needed. The QA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>2. Resident #67's clinical record was reviewed on 9/26/11 at 1:10 p.m. The record indicated on 9/23/11 a Minimum Data Set (MDS) was completed and indicated the resident was frequently incontinent of bladder but still had continent episodes. The MDS indicated the resident had a trial of a toileting program and had decreased wetness.</p> <p>On 6/28/11 a restorative toileting program was started which indicated the resident was usually incontinent, but will urinate on the toilet when placed there. The program indicated the resident was to have been taken to the toilet with 1-2 assist, six times per day, at meals and</p>		<p>sub-committee will review these reports and make any further recommendations or take any further actions deemed necessary to ensure that the needs of residents with urinary incontinence are addressed through individualized plans of care that are followed.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>snacks along with bedtime. The toileting interventions included: "explain we are going to use the toilet, calling me by my name"; "turn on the water, if necessary to encourage me to urinate"; "praise me for any success."</p> <p>On 9/21/11 the restorative toileting program was discontinued. The functional maintenance progress note indicated "0 of 7 days with having at least 4 continent episodes while awake with cueing and 2 assist; resident had maximum of 1 continent episode 6 days."</p> <p>Review of the resident's health care plans indicated no new plan was started for urinary incontinence after the restorative toileting program was discontinued.</p> <p>An interview with LPN #5, the MDS coordinator, on 9/28/11 at 10:00 A.M. indicated resident #67 was discontinued off of the restorative toileting program for urinary incontinence recently due to not meeting goals and indicated the resident now had no formal toileting program for urinary incontinence.</p> <p>3. Resident #79's clinical record was reviewed on 9/26/11 at 2:10 p.m. The record indicated on 7/8/11 a MDS was completed and indicated the resident was frequently incontinent of bladder but still</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>had continent episodes.</p> <p>On 1/20/11 a restorative toileting program was started for incontinence of urine. The program indicated the resident was to have been taken to the toilet with 1-2 assist six times per day, at the 5 meals and snacks along with bedtime. The toileting interventions included "please explain that it is time to use the restroom, calling me by my name"; "please take me to the toilet on a routine basis and also when I ask"; "please preserve my dignity by assisting with my briefs"; "please leave the water run in my sink while I am urinating and allow me to sit for a minute after I am done urinating"; "praise me for any success."</p> <p>On 7/7/11 the restorative toileting program was discontinued for urinary incontinence, noting toileting discontinued for urinary incontinence, very little success with continent issues. The restorative progress: urinary noted "1 of 7 days with having at least 3 continent episodes of urine with cueing and 1 assist."</p> <p>Review of the resident's health care plans indicated no new plan was started for urinary incontinence after the restorative toileting program was discontinued.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
----------------------------------------------	------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>An interview with LPN #5, the MDS coordinator, on 9/28/11 at 10:00 A.M. indicated Resident #67 was discontinued off of the restorative toileting program for urinary incontinence recently due to not meeting goals and indicated the resident now had no formal toileting program for urinary incontinence.</p> <p>4. Resident #40's record was reviewed 9/28/2011 at 1:15 p.m. Resident #40's diagnoses included, but were not limited to, dementia, depression and diabetes.</p> <p>Resident #40's care plan dated 8/17/2011 indicated Resident #40 would be asked to toilet before and after meals and snacks, before bedtime and at night.</p> <p>In a continuous observation on 9/28/2011 between 1:00 p.m. and 3:30 p.m., Resident #40 was observed in a wheelchair, self-propelling through the hallway between 1:00 p.m. and 2:15 p.m. Resident #40 then went to therapy between 2:15 p.m. and 2:40 p.m. At 2:40 p.m., Resident #40 was observed in his chair at the table in the dining area until 3:30 p.m. At 3:30 p.m., Resident #40 was noted to have received his tray and began eating. He had not been toileted.</p> <p>In a continuous observation on 9/29/2011 between 9:00 a.m. and 12:20 p.m., Resident #40 had been noted to be eating</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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>in his wheelchair in the dining area between 9:00 am and 9:20 a.m. At 9:20 a.m., Resident #40 propelled himself away from the table and sat in the dining area until 9:22 a.m. when he propelled himself down the hall and into his room at 9:24 a.m. Resident #40 sat in his room until 9:30 am. when he propelled himself back out to the table in the dining area. At 9:35 Resident #40 was noted to propel himself into his room where he stayed until 10:30 a.m. During this time, Resident #40 got up and his chair alarm went off at 9:47 a.m. and 10:13 a.m. At 10:30 a.m. Resident #40 went to the resident lounge and watched TV until 10:45 a.m. Between 10:45 a.m. and 11:15 a.m. Resident #40 sat in his wheelchair at the table in the dining area. At 11:15 a.m., Resident #40 had propelled himself in his wheelchair in the hall until he went to therapy at 11:25 a.m. Resident #40 was in therapy between 11:25 a.m. and 12:01 p.m. At 12:01 p.m., Resident #40 went to the dining area on the unit where he resided. At 12:20 p.m. Resident #40 remained in the dining area.</p> <p>In an interview on 9/29/2011 at 10 a.m. the Director of Nursing indicated all residents should be toileted at least every 2 hours, and if the toileting schedules are followed, toileting will occur at least every 2 hours and more often.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(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
F0363 SS=E	<p>In an interview on 9/29/2011 at 12:20 p.m. CNA #1 indicated Resident #40 will ask to go to the bathroom or will set his alarm off indicating he must use the restroom. CNA#1 further indicated Resident #40 had been up prior to the start of the shift at 7 a.m. and had not asked to use the rest room.</p> <p>3.1-41(a)(2) Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the menus were followed regarding serving size for 5 of 5 residents requiring a pureed diet and 4 of 4 residents requiring ground meat.</p> <p>Finding includes:</p> <p>During observation of the preparation of the evening meal buffet tray line, conducted on 09/27/11 at 2:30 P.M., dietary aide, employee #14, was noted to dish up the following amounts of pureed and/or mechanically ground food: a #16 (2 ounce) scoop of pureed baked beans and a #16 (2 ounce) sized scoop of pureed corn, and a #16 (2 ounce) serving</p>	F0363	<p>F 363 <u>Corrective action(s) for those identified:</u> On 9/27/11 the dietary aide (employee #14) and the day cook were re-educated regarding the correct portion control (scoop sizes) to be utilized per the menu guide.</p> <p>- <u>Identification of others potentially affected:</u> On 10/11/11, all dietary staff were re-educated regarding the correct portion control (scoop sizes) to be utilized per the menu guide. This re-education also included instruction that, for any resident's special request for a larger or smaller portion, the appropriate scoop will not be placed in the serving pan, but</p>	10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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 ground chicken. Employee #14 indicated the "large portion" ground meats got a #12 (3 ounce) scoop of chicken.</p> <p>Review of the menu guide for the meal, indicated the pureed baked bean was to be a #8 (4 ounce) serving size, the pureed corn was to be a #10 (3 1/2 ounce) serving size, and the ground chicken was to be a #8 (4 ounce) serving size.</p> <p>Interview with the Food service supervisor, on 09/28/11 at 3:00 P.M., indicated the day cook had prepared the food and set up the serving utensils for Employee #14. She indicated she had inserviced him (the day cook) on using the proper scoop sizes.</p> <p>3.1-20(i)(4)</p>		<p>only used when that resident's tray is being serviced.</p> <p><u>Measures to prevent recurrence:</u> Prior to each meal service on the tray line, the cook and prep cook will both review the portions (scoop sizes) for the menu items and set out the appropriate size scoops. Three times weekly, the dietary manager will spot check the portions being served (scoop sizes being used) for the menu items, including spot check to ensure that scoops for special portions requested by residents are kept separate from prescribed scoops. The dietary manager will immediately correct any discrepancies in portions being served and re-educate or discipline staff as needed.</p> <p><u>Monitoring:</u> At each meeting of the QA sub-committee, the dietary manager will report the results of her inspections, as well as whether any corrective actions or disciplinary actions were necessary. The QA sub-committee will review the report and make any further recommendations or take any further actions necessary to ensure that correct portions are being served per the menu, with due consideration for resident requests for larger or smaller portions. At each quarterly meeting, the full Quality Assurance (QA)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	
F0371 SS=D	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure safe storage of thickened liquids in 1 of 4 refrigerators surveyed. This had the potential to affect 3 residents receiving thickened liquids and speech therapy.</p> <p>Findings include:</p> <p>During the environmental tour on 9/27/2011 at 10:22 a.m. the refrigerator in the therapy department was noted to contain honey thickened iced tea 1.5 quarts approximately 1/4 full. The date on the top of the container was noted to be 12/19/2010. There were no other dates on the container.</p> <p>In an interview on 9/29/2011 at 11:10 a.m. the Director of Therapy indicated he was unsure how long the honey thick iced</p>	F0371	<p>Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p> <p>F 371 <u>Corrective action(s) for those identified:</u> The honey-thick iced tea was removed from the refrigerator in the therapy department on 9/27/11.</p> <p>- <u>Identification of others potentially affected:</u> On 9/27/11, the surveyor and staff checked for undated items in other refrigerators and found none.</p> <p><u>Measures to prevent recurrence:</u> The refrigerator in the therapy department will no longer be used to store food items for residents. On 10/13/11 and 10/14/11, nursing staff was retrained regarding proper dating of refrigerated items. By 10/28/11, all dietary staff will be retrained regarding the proper dating of refrigerated items.</p>	10/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>tea had been open. Additionally, there were currently three residents in speech therapy on thickened liquids.</p> <p>In an interview on 9/29/2011 at 11:15 a.m. the dietary manager indicated the date on the tops of the container were the delivery dates and all containers in the facility more than 6 months were to be destroyed and all opened containers were destroyed after three days.</p> <p>A document titled Cold Food Storage provided by the Dietary Manager on 9/27/2011 at 11:20 a.m. indicated under thickened liquids to use the liquids by the manufacturer's date or three days after opening.</p> <p>3.1-21(i)(3)</p>		<p>Three times each week the dietary manager will spot check refrigerated items in the kitchen, checking for proper dating of food items. Whenever the dietary manager identifies any food items with dates missing or food items beyond the "use by" date, she will provide re-education or disciplinary action to dietary staff as needed. Three times each week the dietary manager will also check the refrigerator in the therapy department, in order to ensure that there are no resident food items stored there. The dietary manager will notify the administrator if any resident food items are located in the refrigerator in the therapy department, and the administrator will re-educate or discipline staff as needed.</p> <p>Three times each week the Director of Nursing will spot check refrigerated items in the nursing unit refrigerators used for resident food, checking for proper dating of food items. Whenever the Director of Nursing identifies any food items with dates missing or food items beyond the "use by" date, she will provide re-education or disciplinary action to nursing staff as needed.</p> <p><u>Monitoring:</u> At each meeting of the QA sub-committee, the Director of Nursing and the dietary manager will submit written reports of the results of their inspections,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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	
F0499 SS=D	<p>The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws.</p> <p>Based on record review and interview the facility employed one staff member as a Certified Nursing Assistant (CNA) who did not have a CNA state license in a review of 43 CNAs. (CNA #6)</p> <p>Findings include:</p> <p>Review of facility licensed and certified</p>	F0499	<p>including any issues identified and addressed through re-education or disciplinary action. The QA sub-committee will review the reports and make any further recommendations or take any further actions necessary to ensure that refrigerated food items for residents are properly dated for timely use.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p> <p>F 499 <u>Corrective action(s) for those identified:</u> On 9/29/11 the human resources coordinator (HRC) notified CNA #6 that, effective immediately, she could no longer work as a CNA, since she did not meet state requirements.</p> <p>- <u>Identification of others potentially</u></p>	10/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER CHASE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947		
(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>employees on 9/29/11 at 2:00 P.M. indicated one CNA (#6) was currently working as a CNA without a CNA state license.</p> <p>An interview with the Human Resource Director on 9/29/11 at 3:00 P.M. indicated CNA #6 had completed Fundamentals of Nursing with a grade of a C or better in Nursing school and had one week's training as a CNA at the facility and was currently employed as a CNA in the facility. The Human Resource director indicated CNA #6 did not take the written CNA test.</p> <p>3.1-14(s)</p>		<p><u>affected:</u> The HRC was re-educated regarding requirements for employees being placed on the CNA registry, as specified in "ADMINISTRATIVE STANDARDS FOR THE INDIANA STATE DEPARTMENT OF HEALTH NURSE AIDE TRAINING PROGRAM" and the Indiana Health Facility Rules for Personnel found at 410 IAC 16.2-3.1-14. On 10/12/11 the HRC completed an inspection of the employee files of all nursing assistants to verify that they were properly certified or had met training requirements, if they were still in the four-month window for testing.</p> <p><u>Measures to prevent recurrence:</u> The HRC was re-educated regarding requirements for employees being placed on the CNA registry, as specified in "ADMINISTRATIVE STANDARDS FOR THE INDIANA STATE DEPARTMENT OF HEALTH NURSE AIDE TRAINING PROGRAM" and the Indiana Health Facility Rules for Personnel found at 410 IAC 16.2-3.1-14. In order to validate that the employees meet state requirements to work as a CNA, the HCR will provide the administrator with a written report accompanied by printed documentation of the qualifications of every employee reaching 120 days of employment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2011
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
--------------------------------------------------	------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>and working as a CNA, including those who qualify based on their completion of Fundamentals of Nursing in nursing school and their passing of the written CNA test. The administrator will direct that appropriate action be taken to ensure that every employee working as a CNA is certified to do so, per state requirements.</p> <p><u>Monitoring:</u> At each meeting of the QA sub-committee, the administrator will provide a report of the number of CNAs who have reached 120 days of employment, whether they have been properly certified, and any actions taken to ensure proper certification or appropriate discontinuation of employment. The QA sub-committee will review these reports and make any further recommendations or take any further actions necessary to ensure that only properly qualified employees are working as CNAs.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of each "deficient practice" and the steps for monitoring are carried out as described.</p>	