

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 the Investigation of Complaint IN00129188, Complaint IN00129257 and Complaint IN00129544</p> <p>Complaint IN00129188 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F9999.</p> <p>Complaint IN00129257 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309 and F333.</p> <p>Complaint IN00129544 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F441 and F9999.</p> <p>Survey dates: May 28, 29, 30 and 31, 2013</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey Team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 48 NF: 50</p>	F000000		
---------	--	---------	--	--

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: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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>Total: 108</p> <p>Census payor type: Medicare: 10 Medicaid: 78 Other: 20 Total: 108</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/05/13 by Suzanne Williams, RN</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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			
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician orders for administration of medication and/or oxygen therapy were followed for 2 of 4 residents reviewed for medication administration in a sample of 7. (Resident #F and Resident #B)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #F was reviewed on 5-31-13 at 8:50 a.m. Her diagnoses included, but were not limited to, dementia, COPD (chronic obstructive pulmonary disease), a recent fall resulting in a subdural hematoma, anemia, anxiety and atrial fibrillation.</p> <p>During observation on 5-31-13 at 8:35 a.m., the resident was laying in bed with the head of the bed raised and she did not have her oxygen tubing in place on her face. The oxygen tubing was observed to be lying on top of the oxygen concentrator (machine) and the concentrator was turned off. The resident indicated at this time that she</p>	F000282	F282-Services by qualified persons/per care planThe services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.1. a) Resident F: LPN #2 was re-educated per nursing administration on following MD orders for Oxygen therapy and nebulizers. b) Resident B: Nursing staff were in-serviced per DCS and/or designee on following MD orders and how to document missed doses, including the reason for the missed medication.2. This has the potential to effect residents with orders for O2, resp med orders, and pain med orders.3. The nursing staff was in-serviced per DCS and/or designee on the facility policy/procedure for medication administration including appropriate documentation for omitted doses, refused doses, and prn medication doses, along with the effectiveness of those prn doses.4. a) MARs (med administration records) will be audited daily x one week, then weekly x 4 weeks, then monthly on random units per DCS and/or designee until the QA team	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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>thought the oxygen therapy was a new addition to her care and that she was not having problems with breathing. Resident #F's respiratory rate at this time was 18 breaths per minute and appeared non-labored.</p> <p>Review of Resident #F's admission physician orders, undated for 5-24-13, indicated oxygen therapy at 2 liters via nasal cannula "continuous," and an order for DuoNeb (bronchodilator) 0.5 mg (milligrams)-3 mg, to be administered via a nebulizer machine 3 times daily. Review of the MAR (medication administration record) indicated on the order for DuoNeb the addition of the term "prn," which indicates this medication is to be administered only as needed. The parameters for administering the medication on an as needed basis were not included. The MAR indicated there had not been any doses of this medication administered since admission.</p> <p>In interview with LPN #2 on 5-31-13 at 9:25 a.m., she indicated, "I'm in the process of weaning her off her O-2 (oxygen therapy). I've been checking her O-2 sats (saturation rates of oxygen in the blood) on a regular basis. I have to be able to show the doctors how she is doing without the</p>		<p>determines the issue is resolved.</p> <p>b) Audits will be reviewed by the interdisciplinary team monthly in the QA meeting, then quarterly in QA meeting with the Medical Director.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6-30-13.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>O-2 before I call them. I will go check her sat." When she returned at 9:26 a.m., she indicated the resident's oxygen saturation rate was 96% on room air and that she had replaced Resident #F's oxygen. In observation of Resident #F at 9:43 a.m., the resident was wearing her oxygen tubing on her face and the oxygen concentrator was turned on and at 2 liters.</p> <p>Review of a physician's progress note, dated 5-30-13, indicated the resident's chart had been reviewed and planned to continue the same medications for the present time. There were no notations listed to make changes to her oxygen therapy.</p> <p>Review of the nursing notes indicated the following: 5-25-13 between 6:00 a.m. and 10:00 p.m.: "O-2 weaned off with sats in 94% to 96% range on room air over the course of day & evening." 5-26-13 at 12:40 a.m.: O-2 sat 95% on room air. 5-26-13 at 10:00 p.m.: O-2 on at 2 liters continuously. 5-27-13 at 3:55 a.m.: O-2 sat down to 81% on room air; O-2 replaced at 2 liters and O-2 sats were raised to 98%. 5-27-13 at 9:00 p.m.: O-2 on at 2</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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>liters with O-2 sat at 97%. 5-28-13 at 3:30 a.m.: O-2 sat 93% on room air. 5-29-13 at 3:15 a.m.: O-2 sat 95% on 2 liters of O-2. 5-30-13 at 4:15 a.m.: O-2 sat 94% on 2 liters of O-2. 5-31-13 at 4:00 a.m.: O-2 sat 92% on 2 liters of O-2.</p> <p>In interview with the Director of Nursing on 5-31-13 at 10:15 a.m., she indicated LPN #2 "knows she has to have an order [from the attending physician] for weaning the O-2."</p> <p>2. Resident #B's clinical record was reviewed on 5-29-13 at 3:35 p.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), anxiety, cervicalgia constitution, joint pain and RLS (restless leg syndrome). Physician progress notes indicated he had 21 teeth extracted on 5-13-13 by an oral surgeon. His admission Minimum Data Set (MDS) assessment, dated 4-26-13, indicated he was cognitively intact.</p> <p>Review of Resident #B's current physician orders indicated he was ordered to receive hydrocodone-acetaminophen (a narcotic pain reliever) 7.5-325 mg</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>(milligrams) every 4 hours around the clock by mouth. Review of the "Controlled Substances Record" for hydrocodone-acetaminophen 7.5-325 mg indicated the resident did not receive a scheduled dose of this on 5-10-13 at 1:00 p.m. and did not receive two consecutively scheduled doses of this medication on 5-16-13 at the times of 9:00 a.m. and 1:00 p.m. Review of the nursing notes for these dates did not indicate these doses were omitted. Review of the MAR (medication administration record) for 5-10-13 at 1:00 p.m. indicated the dose was initialed which represents it was administered. The MAR for 5-16-13 for the 9:00 a.m. and 1:00 p.m. doses indicated the initials were present, but circled which represents it was not administered. The MAR did not indicate the reason the medication was not administered.</p> <p>In interview with Resident #B on 5-29-13 at 3:25 p.m., he indicated he had some issues related to receiving his pain medications. He did not specify what those issues were upon request for clarification.</p> <p>On 5-30-13 at 9:15 a.m., the Director of Nursing provided a copy of a policy entitled, "6.0 General Dose Preparation and Medication</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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>Administration." This policy indicated, "Facility staff should: verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct rate, at the correct time, for the correct resident...Document the administration of controlled substances in accordance with Applicable Law...After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: Document necessary medication administration/treatment information (e.g.,...if medications are refused...)..."</p> <p>This Federal tag relates to Complaint IN00129257.</p> <p>3.1-35(g)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure pain assessments were conducted for residents with chronic pain and/or receiving pain medications for 2 of 4 residents reviewed for pain in a sample of 7. (Residents #A and #C)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #A was reviewed on 5-28-13 at 3:31 p.m. His diagnoses included, but were not limited to diabetes, osteoporosis, Alzheimer's dementia, coronary artery disease (heart disease), angina, and hemiplegia (paralysis on one side). His most recent Minimum Data Set (MDS) assessment, dated 5-20-13, indicated he was severely cognitively impaired, requires extensive assistance of one person with transfers and mobility, does not walk, and uses a wheelchair for mobility.</p> <p>In review of Resident A's current physician-ordered medication</p>	F000309	F309-Provide Care/Services for Care/Well-being.This facility does ensure resident's receive pain medications to maintain their highest practicable physical, mental, and psychosocial well-being.1. a) A pain assessment was completed for resident A and pain medications were evaluated for effectiveness per nursing. b) Resident C was discharged to home on 5-31-13.2. Current residents will have a pain assessment completed per nursing staff to ensure their current pain medication/dosage is effective.3. In-serviced nursing staff per DCS and/or designee on facility policy/procedure for pain assessments, which are to be completed on admission by the admitting nurse, and also reviewed the process for re-admission, quarterly, annual, and any significant change in condition. 4. a) The DCS and/or designee will QA monitor daily for the initial completion of pain assessments for current residents. b) The MDS Coordinator and/or designee will	06/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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>regimen, it indicated he received hydrocodone-acetaminophen (a narcotic pain reliever) 5/500 milligram (mg) twice daily by mouth, as well as had an order for this to be received of one tablet every 4 hours as needed for pain. In addition, he had a Tylenol (acetaminophen) 325 mg order for which he could receive 2 tablets every 4 hours by mouth as needed for pain or fever.</p> <p>Review of Resident #A's clinical record failed to indicate the presence of a pain assessment tool. In interview with the Director of Nursing (DON) on 5-29-13 at 11:50 a.m., she indicated she could not locate quarterly pain assessments for Resident #A. She indicated, "I had no idea these were not being done." In interview with the DON on 5-31-13 at 12:50 p.m., she indicated she had facility staff review Resident #A's "overflow file [all old and current clinical information] and they couldn't find any pain assessments."</p> <p>In interview with MDS Coordinator #2 on 5-29-13 at 10:15 a.m., she indicated, "The staff does ask him how he's doing, but it's not routinely charted." She indicated there had not been quarterly pain assessments conducted. She indicated she was</p>		<p>designate a nurse for all re-admission, quarterly, annual, and significant change pain assessments as scheduled, and will track for completion. If assessments are not completed timely, the MDS Coordinator will notify the DCS. This will be an ongoing process.5. This plan of correction constitutes our credible allegations of compliance with all regulatory requirements. Our date of compliance is 6-30-13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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 sure what the policy was for conducting pain assessments.</p> <p>2. The clinical record for Resident #C was reviewed on 5-28-13 at 4:32 p.m. His diagnoses included, but were not limited to, alcoholic cardiomyopathy, congestive heart failure, anxiety and history of alcoholism and respiratory failure.</p> <p>In review of Resident C's current physician-ordered medication regimen, it indicated he received ibuprofen 600 mg every 12 hours by mouth as needed for pain. Review of the April, 2013 MAR (medication administration record) indicated he received this medication 23 out of 30 days in April. The May, 2013 MAR indicated he had new physician-ordered pain medications related to a dental procedure on 5-6-13 for which he received ibuprofen 400 mg every 6 hours by mouth for 5 days, beginning 5-7-13, and hydrocodone-acetaminophen 5-325 mg every 6 hours for 20 tablets, beginning 5-7-13.</p> <p>Review of Resident #C's clinical record indicated a pain assessment tool was conducted upon admission on 9-14-12, but failed to indicate any pain assessment tools after that date.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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 interview with the Director of Nursing (DON) on 5-29-13 at 11:50 a.m., she indicated she could not locate quarterly pain assessments for Resident #C. She indicated, "I had no idea these were not being done."</p> <p>In interview with MDS Coordinator #2 on 5-29-13 at 10:15 a.m., she indicated, "The staff does ask him how he's doing, but it's not routinely charted." She indicated there had not been quarterly pain assessments conducted. She indicated she was not sure what the policy was for conducting pain assessments at the facility.</p> <p>On 5-29-13 at 2:50 p.m., the Business Office Manager provided a copy of a policy entitled, "Pain Assessment." This policy indicated, "Residents will be assessed for pain upon admission, readmission, quarterly, annually, upon significant change, when a resident experiences a new onset of pain or experiencing uncontrolled pain."</p> <p>This Federal tag relates to Complaint IN00129257.</p> <p>3.1-37(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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
F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident did not elope from the facility for 1 of 5 residents reviewed for elopement risk in a sample of 7. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 5-28-13 at 3:31 p.m. His diagnoses included, but were not limited to Alzheimer's dementia, coronary artery disease (heart disease) and hemiplegia (paralysis on one side). His most recent Minimum Data Set (MDS) assessments, dated 3-1-13, indicated he was moderately cognitively impaired and on 5-20-13, severely cognitively impaired. An "Elopement Risk Assessment," dated 12-31-12, with review dates of 1-17-13, 4-18-13, 5-13-13 and 5-23-13, indicated the resident was determined to be at risk of elopement. It indicated he had a wanderguard in place.</p>	F000323	<p>F323-Free of Accident/Hazards/Supervision/Devices The facility does ensure that the environment remains as free of accident/hazards as possible.1. Re: Resident A, the door alarm sounded appropriately when resident exited the facility door. Staff did not respond as quickly as is expected.2. a) 100% QA review of all doors for appropriate alarming was completed per maintenance department staff. b) All residents with wander guards were tested for triggering the door alarms per SSD with no identified issues. c) Residents with the wander guard equipment have the potential to be effected.3. In-serviced all staff per DCS/Administrator on the staff's responsibility and expected response to the wander guard alarm.4. a) The Maintenance Director and/or designee will perform testing of the door alarms daily. This is an ongoing process. b) The Maintenance Director and/or designee will test all resident wander guards weekly for appropriate triggering of the door alarm system. This is an ongoing process. c) Social</p>	06/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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 Resident #A's nursing notes, dated 5-12-13 at 6:55 p.m., indicated LPN #1 was notified by a staff member that, "resident exited the building through front door, sounding [the] alarm. Res [resident] seen leaving [facility] parking lot via w/c [wheelchair], cross road and go to [toward] neighboring apartments." The nursing notes indicated the staff member was able to reach the resident and re-direct him back to the facility. Nursing notes indicated the resident was placed on 15 minute observational checks and the physician, family and Director of Nursing were notified of the event.</p> <p>In interview with CNA #1 on 5-29-13 at 10:28 a.m., she indicated the front door alarm was activated on 5-12-13 between 6:30 p.m. and 7:00 p.m., and she heard the alarm while she was working on the A-hall. She indicated she was not sure how long it took her to get from the unit to the front door to check out the alarm. She indicated when she did get to the front door of the facility, she saw a male person in a wheelchair who was already across the street, near the fire hydrant. CNA #1 indicated her first instinct was to see if Resident #A was near the D-hall door, waiting for the 7:30 p.m. smoke break. She</p>		<p>Services Director and/or designee will track all wander guards for each resident for the necessary annual change. This is an on-going process. d) Social Services Director and/or designee will conduct a monthly elopement drill to ensure staff respond appropriately. e) Nursing will check every shift to ensure the wander guard bracelets are in place for all residents who require their use. This is an on-going process. f) All monitoring tools and tracking will be reviewed in the next morning meeting, Monthly QA meeting, and Quarterly in the QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6-30-13.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 she turned away from the front door and went down the hall to the D-hall door and did not find Resident #A there. She indicated, "I immediately knew then it was him. So I went out he D-hall door and ran up front...When I went running after him, he was still near there, he was near the fire hydrant." She indicated the following day, the Social Services Designee (SSD) spoke with her. She indicated the SSD told her she should have gone directly to the resident, not check the resident's smoking area first.</p> <p>In interview with LPN #1 on 5-29-13 at 2:12 p.m., she indicated on 5-12-13, she recalled seeing Resident #A in the dining area near D-hall around 6:30 p.m. She indicated shortly thereafter, near 6:45 p.m., she recalled seeing Resident #A in the D-hall waiting to go out to the next scheduled smoke break. She indicated she then went to provide care to another resident. She indicated when she came out of the other resident's room, she was informed CNA #1 needed to speak to her. She indicated she was then informed by CNA #1 "what happened to [name of Resident #A.]" She indicated she located the resident in his room at approximately 7:15 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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 conducted a physical assessment that was normal. She indicated she checked his wanderguard alarm and it was functioning correctly. She indicated the wanderguard was placed on a bar, below the seat of the wheelchair. She indicated at this point, she instituted 15 minute observation checks on Resident #A.</p> <p>In interview with the Director of Nursing on 5-29-13 at 11:50 a.m., she indicated Resident #A's wanderguard was an audible alarm only and did not lock the facility doors when activated.</p> <p>This Federal tag relates to Complaint IN00129188.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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			
F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error related to receiving an antibiotic which the resident was allergic to. This deficient practice affected 1 of 4 residents reviewed for medications in a sample of 7. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 5-29-13 at 3:35 p.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), anxiety and pneumonia. His admission Minimum Data Set (MDS) assessment, dated 4-26-13, indicated he was cognitively intact. The admission nursing collection tool, the demographics/face sheet, and the initial physician's examination note, dated 4-25-13, indicated the resident was allergic to penicillin.</p> <p>In interview with Resident #B on 5-29-13 at 3:25 p.m., he indicated he had received an incorrect medication previously during this admission to</p>	F000333	F333-Residents Free of significant med errorsThe facility does ensure the residents are free from significant medication errors.1. Resident B; The resident received one dose of the antibiotic and did not have any adverse reaction to the dose. MD and Family were notified of the issue.2. Residents with allergies to antibiotics would have the potential to be effected.3. a) Nursing staff was in-serviced on policy and procedure per DCS/designee for medication administration, including checking for allergies. b) Medical Records/designee will complete a 100% QA review of resident records to ensure that allergies are identified on the chart, and will ensure all medication administration records have allergies listed. These are on-going processes.4. a) The DCS/designee will QA monitor antibiotics as ordered for one month to ensure no allergies are identified. b) Medical Records/designee will review QA monitor tools completed at monthly QA meeting, and quarterly at the QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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 facility.</p> <p>Review of physician progress notes indicated the resident was seen by an area dentist on 4-24-13. Physician orders indicated on this date, the dentist ordered Amoxicillin (a penicillin derivative) 500 milligrams every 8 hours for 10 days by mouth related to "advanced periodontal disease."</p> <p>Nursing notes indicated the Amoxicillin was obtained from the EDK (emergency drug kit) and administered to the resident on 4-24-13 at 2:00 p.m. The MAR (Medication Administration Record) for April, 2013 indicated this medication was administered once on 4-24-13 at 1:00 p.m. Nursing notes on 4-24-13 at 6:00 p.m. indicated the antibiotic was discontinued at that time due to allergies to the medication. Review of the subsequent nursing notes did not indicate any adverse side effects in the days following the receipt of the medication.</p> <p>An undated physician order form indicated to discontinue the Amoxicillin and a non-penicillin derivative was then ordered on 4-25-13 by the attending physician.</p>		Our date of compliance is 6-30-13.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 5-30-13 at 9:15 a.m., the Director of Nursing provided a copy of a policy entitled, "6.0 General Dose Preparation and Medication Administration." This policy indicated, "...Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:...Check for allergies to the medication..."</p> <p>This Federal tag relates to Complaint IN00129257.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>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 Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to ensure the</p>	F000441	F441-Infection Control, Prevent Spread, LinensThis facility's	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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>rooms of residents with the diagnosis of clostridium difficile (c-diff) were properly cleaned with approved cleaning agents to diminish the potential spread of this organism for 1 of 1 resident reviewed for environmental concerns in a sample of 7, with the potential to affect other residents in the facility. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 5-29-13 at 3:35 p.m. His diagnoses included, but were not limited to, positive c-diff stool culture on 5-27-13, COPD (chronic obstructive pulmonary disease), anxiety and pneumonia. His admission Minimum Data Set (MDS) assessment, dated 4-26-13, indicated he was cognitively intact.</p> <p>In interview with Resident #B on 5-29-13 at 3:25 p.m., he indicated he learned of the c-diff diagnosis a few days prior. He indicated he was familiar with how contagious the illness can be.</p> <p>In interview with Housekeeper #1 on 5-31-13 at 10:15 a.m., she indicated that the housekeeping services are a contracted service for the facility. She indicated she is not always</p>		<p>infection control policies related to cleaning resident rooms with approved cleaning agents will be followed.1. Resident B; The room was appropriately cleaned with approved products.2. This would effect residents with C diff.3. The contracted company has in-serviced all housekeeping staff on appropriate cleaning of resident rooms/bathrooms with approved cleaning agents, deep cleaning resident rooms/bathrooms after discharge, and appropriate cleaning of isolation rooms. The housekeepers have a checklist to follow, and these will be turned in to their supervisor as each discharged room has been cleaned, and daily with each isolation room cleaning. These checklists will be reviewed up to 5 days per week in daily meeting. This will be an ongoing process.</p> <p>4. a) The housekeeping supervisor will complete QA reviews on discharge rooms and isolation rooms after daily meetings 5 days per week. b) The interdisciplinary team will monitor during QA rounds for adherence to the proper cleaning of discharge rooms and isolation rooms. c) QA monitoring tools will be reviewed in a.m. meetings, monthly QA meetings per the IDT, and quarterly with the Medical Director in QA meetings.5. This plan of correction constitutes our credible allegation of compliance with all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>aware of any resident rooms that may need special attention, such as residents on contact isolation for problems such as c-diff. She indicated she was unaware of where the company's written policies are located in the facility for special cleaning, such as for c-diff. She indicated she had not been given any special instructions or different instructions for daily cleaning of resident rooms or their bathrooms for residents in isolation, other than the usual cleaning procedures and using the routine products.</p> <p>She indicated recently, after a meeting with the Director of Nursing and the Regional Manager of the housekeeping services, disinfectant wipes and 2 gallons of bleach were purchased. She indicated the disinfectant wipes were to be used for deep cleaning or "turnover cleaning," as in when a resident is discharged from a room and prior to a new resident occupying the area. She indicated she had only been using the disinfectant wipes for cleaning in the staff breakroom area. She indicated she was instructed to use the bleach when mopping the floors of residents identified with c-diff. She indicated she had been using the routine cleaning products for daily cleaning of</p>		regulatory requirements. Our date of compliance is 6-30-13.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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 rooms of residents with c-diff. She indicated that when mopping the isolation rooms, she does not re-dip the mop and after mopping is completed in that room, she removes the mop head and bags it up for laundering prior to exiting the room.</p> <p>Housekeeper #1 provided a bottle of the disinfectant wipes that were recently purchased for cleaning in the facility. The label was observed to indicate, "Disinfectant Wipes," and was indicated to be from an area discount store. The active ingredients listed were indicated as "alkyl dimethyl benzyl ammonium chloride" 0.14% and "alkyl dimethyl ethylbenzyl ammonium chloride" 0.14%. The label indicated the product was alcohol-free. The label did not indicate it was effective against the pathogen of clostridium difficile.</p> <p>Housekeeper #1 provided MSDS (Material Safety Data Sheet) information, as well as copies of the products labels for the cleaning agents she indicated are currently used for general cleaning and bathroom disinfection on 5-3-13 at 11:20 a.m. Neither product indicated it was effective against the pathogen of clostridium difficile.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 5-31-13 at 12:50 p.m., the Administrator provided information faxed to the facility on the same date from the company which contracts the housekeeping services to the facility. The documentation included a document entitled, "Environmental Cleaning Checklist for Isolation Rooms." This checklist indicated the resident rooms, resident bathrooms and resident floors of isolation rooms are to be disinfected with a "hypochlorite based disinfectant (1:10 bleach equivalent)..." It indicated this same solution should be used for terminal cleaning of resident rooms, as well.</p> <p>In interview with the Director of Nursing on 5-31-13 at 12:50 p.m., she indicated she had met with the the Regional Manager of the housekeeping services about using bleach to clean the rooms of any resident identified with c-diff. She indicated she thought it was understood this should be done on a daily basis, not with only terminal cleaning of the room.</p> <p>"Clostridium difficile (CDI) Infections Toolkit" (draft date 12-23-09) indicated bleach can kill the c-diff spores, whereas other disinfectants in their study did not do so. It indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>a standard bleach solution of 1 part bleach to 10 parts water, prepared fresh daily for environmental cleaning, may reduce the transmission of c-diff. This article was retrieved from the Centers of Disease Control website www.cdc.gov on 6-1-13.</p> <p>"Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for the Healthcare Epidemiology of America (SHEA) and the Infectious Disease Society of American (IDSA)" (published May, 2010) indicated current evidence supported the use of chlorine-containing agents or known sporicidal agents for disinfection of the environment of known c-diff locations. This article was retrieved from the Centers of Disease Control website www.cdc.gov on 6-1-13.</p> <p>This Federal tag relates to Complaint IN00129544.</p> <p>3.1-18(b)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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	
F009999	<p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(g) The administrator is responsible for the overall management of the facility, but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident...</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure an occurrence of resident elopement from the facility for 1 of 5 residents reviewed for elopement risk in a sample of 7 was reported to the Indiana State Department of Health (ISDH). (Resident #A)</p> <p>Findings include:</p>	F009999	<p>9999-Administration and managementThis facility does normally report elopements.1. Resident A; The ISDH is aware of the elopement.2. 100% review of all doors for appropriate alarming was completed per DCS, with assistance from SSD and Maintenance staff, with no issues identified. All current residents with wandergaurds were tested to ensure that the door alarms would trigger, and no issues were identified. All residents with wander gaurds have the potential to be effected.3. The Administrator and SSD in-serviced the facility staff on their responsibility for responding to the Wander Guard Alarm system, and on policy/procedure for reporting all occurrences that are inconsistent with the routine of the facility or the routine care of a particular resident. 4. The Administrator/SSD will review all occurrences to ensure that all incidents which meet the metioned criteria are reported to the ISDH. Any events will be reviewed in a.m. QA meeting. This will be an ongoing process. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6-30-13.</p>	06/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 clinical record of Resident #A was reviewed on 5-28-13 at 3:31 p.m. His diagnoses included, but were not limited to Alzheimer's dementia, coronary artery disease (heart disease) and hemiplegia (paralysis on one side). His most recent Minimum Data Set (MDS) assessments, dated 3-1-13, indicated he was moderately cognitively impaired and on 5-20-13, severely cognitively impaired. An "Elopement Risk Assessment," dated 12-31-12, with review dates of 1-17-13, 4-18-13, 5-13-13 and 5-23-13, indicated the resident was determined to be at risk of elopement. It indicated he had a wanderguard in place.</p> <p>Review of Resident #A's nursing notes, dated 5-12-13 at 6:55 p.m. indicated LPN #1 was notified by a staff member that, "resident exited the building through front door, sounding [the] alarm. Res [resident] seen leaving [facility] parking lot via w/c [wheelchair], cross road and go to [toward] neighboring apartments." The nursing notes indicated the staff member was able to reach the resident and re-direct him back to the facility. Nursing notes indicated the resident was placed on 15 minute observational checks and the physician, family and Director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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>Nursing were notified of the event.</p> <p>In interview with CNA #1 on 5-29-13 at 10:28 a.m., she indicated the front door alarm was activated on 5-12-13 between 6:30 p.m. and 7:00 p.m.. She indicated she heard the alarm while she was working on the A-hall. She indicated she was not sure how long it took her to get from the unit to the front door to check out the alarm. She indicated when she did get to the front door of the facility, she saw a male person in a wheelchair who was already across the street, near the fire hydrant. She indicated her first instinct was to see if Resident #A was near the D-hall door, waiting for the 7:30 p.m. smoke break. She indicated she turned away from the front door and went down the hall to the D-hall door and did not find Resident #A there. She indicated, "I immediately knew then it was him. So I went out he D-hall door and ran up front...When I went running after him, he was still near there, he was near the fire hydrant." She indicated the following day, the Social Services Designee (SSD) spoke with her. She indicated the SSD told her she should have gone directly to the resident, not check the resident's smoking area first.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265			
(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 interview with LPN #1 on 5-29-13 at 2:12 p.m., she indicated on 5-12-13, she recalled seeing Resident #A in the dining area near D-hall around 6:30 p.m. She indicated shortly thereafter, near 6:45 p.m., she recalled seeing Resident #A in the D-hall waiting to go out to the next scheduled smoke break. She indicated she then went to provide care to another resident. She indicated when she came out of the other resident's room, she was informed CNA #1 needed to speak to her. She indicated she was then informed by CNA #1 "what happened to [name of Resident #A.]" She indicated she located the resident in his room at approximately 7:15 p.m. and conducted a physical assessment that was normal. She indicated she checked his wanderguard alarm and it was functioning correctly. She indicated the wanderguard was placed on a bar, below the seat of the wheelchair. She indicated at this point, she instituted 15 minute observation checks on Resident #A.</p> <p>In interview with the Director of Nursing on 5-29-13 at 11:50 a.m., she indicated Resident #A's wanderguard was an audible alarm only and did not lock the facility doors when activated.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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 interview with the Administrator on 5-28-13 at 5:31 p.m., he indicated the elopement of Resident #A was not reported to ISDH.</p> <p>In interview with the Social Services Designee (SSD) on 5-29-13 at 8:25 a.m., she indicated she had the events of the elopement of Resident #A ready to be sent to ISDH as a reportable event the day after the elopement. She indicated prior to sending the report to ISDH, there was a conference call between facility staff and some of the corporate staff in which the corporate staff did not think the elopement was a reportable event. The SSD indicate the corporate staff's decision that the event was not reportable related to the resident was not missing for any length of time and the staff responded appropriately to the alarm of the wanderguard on the resident's wheelchair.</p> <p>On 5-28-13 at 3:05 p.m., the Administrator provided a copy of a policy entitled, "Incident & Accident Management." It indicated, "Incident/Accident identification and reporting are the responsibility of all employees of the building...An incident is defined as: Any</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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>occurrence that is inconsistent with the routine operations of the facility or the routine care of a particular resident/patient...An electronic Incident/Accident Report is completed for incidents involving resident/patients and visitors as soon as possible after the occurrence, no later than 24 hours after the occurrence."</p> <p>This state tag relates to Complaint IN00129188.</p> <p>3.1-13(g)</p>			