

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 9, 10, 11, 12, 15, 2013.</p> <p>Facility number: 000532 Provider number: 155527 Aim number: 100267180</p> <p>Survey team: Ginger McNamee, RN, TC Betty Retherford, RN July 9, 2013 Karen Lewis, RN Tina Smith-Staats, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 47 Total: 54</p> <p>Census payor type: Medicare: 7 Medicaidd: 39 Other: 8 Total: 54</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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 record review and interview, the facility failed to ensure blood pressures and/or pulses were obtained prior to the administration of medication as needed per plan of care for 3 of 10 residents reviewed for unnecessary medications. (Resident #'s 63, 48, 26)</p> <p>Findings include:</p> <p>1.) Resident #63's clinical record was reviewed on 7/11/13 at 9:05 a.m. The resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and severe aortic regurgitation.</p> <p>The resident had current physician's orders signed and dated by the physician on 5/15/13. The resident had an order for lisinopril [a blood pressure medication] 5 milligrams [mg] 1 tablet by mouth every day and hold the medication if the systolic blood pressure was less than 115.</p> <p>Review of the Medication Administration Record for May of</p>	F000282	<p>1. Residents 63, 48 and 26 physicians and families notified. Residents assessed with no negative outcomes from the lack of monitoring of Pulse and/or Blood Pressure. Clarification from physician to continue to monitor Pulse and Blood Pressure per physician order.2. All residents' records were reviewed to assure Blood Pressure/Pulse monitored per physician's orders and care plan. Nursing staff re-educated on medication administration and adequate monitoring of residents prescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan (see attachment c). The DON and/or designee will audit Medication Administration Records 5xs weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A). Should concerns be noted, corrective action shall be taken.3. In order to ensure this deficient practice does not recur, Nursing staff were re-educated on medication administration and</p>	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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>2013, indicated the resident had received the lisinopril 5 mg every morning at 8:00 a.m., and lacked an indication of the blood pressure being obtained prior to the administration.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's blood pressure had been taken prior to the administration of the medication.</p> <p>2.) Resident #48's clinical record was reviewed on 7/11/13 at 10:16 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and high cholesterol.</p> <p>The resident's current physician's orders were signed by the physician on 6/27/13. The resident had an order for digoxin [a heart medication] 0.125 mg give 1 tablet by mouth every other day for atrial fibrillation.</p> <p>Review of the Medication Administration Records for May and June 2013, indicated the digoxin was given every other day as ordered. The records lacked an indication of the resident's pulse being monitored prior to the medication being administered.</p>		adequate monitoring of residents prescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan (see attachment C). The DON and/or designee will audit Medication Administration Records 5x weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A).4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the Quality Assurance Committee monthly x 3 months and quarterly thereafter. Revisions will be made to the plan, if warranted based upon findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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 "2010 Nursing Spectrum Drug Handbook" indicated the following as patient monitoring for digoxin: "Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber."</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's pulse had been taken prior to the administration of the medication.</p> <p>3.) The clinical record for Resident #26 was reviewed on 7/11/13 at 2:17 p.m.</p> <p>Diagnoses for Resident #26 included, but were not limited to, hypertension, diabetes, atrial fibrillation, and depression.</p> <p>A health care plan problem, dated 4/13/13, indicated Resident #26 had a diagnosis of hypertension. Interventions for this problem included monitor blood pressure, notify physician per call order parameters, and administer medications as ordered.</p> <p>A health care plan problem, dated 5/15/13, indicated Resident #26</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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>required the use of lanoxin (heart medication). Interventions for this problem included administer medication as ordered and hold the scheduled dose if the resident's heart rate is below 60 or above 120.</p> <p>A physician's order, dated 5/10/10, indicated Bystolic (a blood pressure medication) 10 milligrams (mg) 1 tablet by mouth every day was to be given and the medication to be held if systolic blood pressure was less than 120.</p> <p>A physician's order, dated 5/15/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 2 tablets by mouth every day for 4 days.</p> <p>A physician's order, dated 5/20/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 1 tablet by mouth every day.</p> <p>The Medication Administration Record (MAR) for May 2013, indicated the blood pressure on 5/5/13 was 119/72, and on 5/27/13 the blood pressure was 106/59. The Bystolic had been given on both days even though the systolic blood pressure was less than 120.</p> <p>The June 2013, MAR indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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>blood pressure on 6/30/13 was 115/76. The Bystolic had been given on this date.</p> <p>The May 2013, MAR indicated the resident started receiving the lanoxin on 5/16/13. No pulses were obtained from 5/16/13 to 5/31/16. The resident received the lanoxin 16 times in May.</p> <p>The "2010 Nursing Spectrum Drug Handbook" indicated the following as patient monitoring for digoxin: "Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber."</p> <p>During an interview with the Director of Nursing on 7/12/13 at 10:35 a.m., additional information was requested related to the blood pressure and pulse monitoring before medication administration.</p> <p>The facility failed to provide any additional information as of exit on 7/15/13 at 3:15 p.m.</p> <p>3.1-35(g)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure blood pressures and/or pulses were obtained to ensure medications were necessary prior to being administered for 3 of 10 residents reviewed for unnecessary medications. (Resident #'s 63, 48, 26)</p> <p>Findings include:</p> <p>1.) Resident #63's clinical record was reviewed on 7/11/13 at 9:05 a.m. The</p>	F000329	<p>1. Residents 63, 48 and 26 physicians and families notified. Residents assessed with no negative outcomes from the lack of monitoring of Pulse and/or Blood Pressure. Clarification from physician to continue to monitor Pulse and Blood Pressure per physician order.2. All residents' records were reviewed to assure Blood Pressure/Pulse monitored per physician's orders and care plan. Nursing staff re-educated on medication administration and adequate monitoring of residents</p>	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and severe aortic regurgitation.</p> <p>The resident had current physician's orders signed and dated by the physician on 5/15/13. The resident had an order for lisinopril [a blood pressure medication] 5 milligrams [mg] 1 tablet by mouth every day and hold the medication if the systolic blood pressure was less than 115.</p> <p>Review of the Medication Administration Record for May of 2013, indicated the resident had received the lisinopril 5 mg every morning at 8:00 a.m., and lacked an indication of the blood pressure being obtained prior to the administration.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's blood pressure had been taken prior to the administration of the medication.</p> <p>2.) Resident #48's clinical record was reviewed on 7/11/13 at 10:16 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and high cholesterol.</p>		<p>prescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan (see attachment c). The DON and/or designee will audit Medication Administration Records 5 xs weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A). Should concerns be noted, corrective action shall be taken.3. In order to ensure this deficient practice does not recur, Nursing staff were re-educated on medication administration and adequate monitoring of residentsprescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan (see attachment C). The DON and/or designee will audit Medication Administration Records 5x weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A).4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the Quality Assurance Committee monthly x 3 months and quarterly thereafter. Revisions will be made to the plan, if warranted based upon the findings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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 resident's current physician's orders were signed by the physician on 6/27/13. The resident had an order for digoxin [a heart medication] 0.125 mg give 1 tablet by mouth every other day for atrial fibrillation.</p> <p>Review of the Medication Administration Records for May and June 2013, indicated the digoxin was given every other day as ordered. The records lacked an indication of the resident's pulse being monitored prior to the medication being administered.</p> <p>The "2010 Nursing Spectrum Drug Handbook" indicated the following as patient monitoring for digoxin: "Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber."</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's pulse had been taken prior to the administration of the medication.</p> <p>3.) The clinical record for Resident #26 was reviewed on 7/11/13 at 2:17 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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>Diagnoses for Resident #26 included, but were not limited to, hypertension, diabetes, atrial fibrillation, and depression.</p> <p>A physician's order, dated 5/10/10, indicated Bystolic (a blood pressure medication) 10 milligrams (mg) 1 tablet by mouth every day. Hold medication if systolic blood pressure is less than 120.</p> <p>A physician's order dated 5/15/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 2 tablets by mouth every day for 4 days.</p> <p>A physician's order dated 5/20/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 1 tablet by mouth every day.</p> <p>The Medication Administration Record (MAR) for May 2013, indicated the blood pressure on 5/5/13 was 119/72, and on 5/27/13 the blood pressure was 106/59. The Bystolic had been given on both days.</p> <p>The June 2013, MAR indicated the blood pressure on 6/30/13 was 115/76. The Bystolic had been given on this date.</p> <p>The May 2013, MAR indicated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident started receiving the lanoxin on 5/16/13. No pulses were obtained from 5/16/13 to 5/31/16. The resident received the lanoxin 16 times in May.</p> <p>The "2010 Nursing Spectrum Drug Handbook" indicated the following as patient monitoring for digoxin: "Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber."</p> <p>During an interview with the Director of Nursing on 7/12/13 at 10:35 a.m., additional information was requested related to the blood pressure and pulse monitoring before medication administration.</p> <p>The facility failed to provide any additional information as of exit on 7/15/13 at 3:15 p.m.</p> <p>3.1-48(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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			
F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the Consultant Pharmacist identified the lack of blood pressure and/or pulse monitoring for resident's receiving medications requiring the monitoring of the blood pressure and/or pulse prior to the administration of the medications for 3 of 10 residents review for unnecessary medications. (Resident #'s 63, 48, 26)</p> <p>Findings include:</p> <p>1.) Resident #63's clinical record was reviewed on 7/11/13 at 9:05 a.m. The resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and severe aortic regurgitation.</p> <p>The resident had current physician's orders signed and dated by the physician on 5/15/13. The resident had an order for lisinopril [a blood</p>	F000428	<p>1. Residents 63, 48 and 26 physicians and families notified. Residents assessed with no negative outcomes from the lack of monitoring of Pulse and/or Blood Pressure. Clarification from physician to continue to monitor Pulse and Blood Pressure per physician order.2. All residents' records were reviewed to assure Blood Pressure/Pulse monitored per physician's orders and care plan. Nursing staff re-educated on medication administration and adequate monitoring of residents prescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan. (see attachment c). The DON and/or designee will audit Medication Administration Records 5 xs weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A). 3. In order to ensure this deficient practice does not recur,</p>	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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>pressure medication] 5 milligrams [mg] 1 tablet by mouth everyday and hold the medication if the systolic blood pressure was less than 115.</p> <p>Review of the Medication Administration Record for May of 2013, indicated the resident had received the lisinopril 5 mg every morning at 8:00 a.m., and lacked an indication of the blood pressure being obtained prior to the administration.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's blood pressure had been taken prior to the administration of the medication.</p> <p>The clinical record indicated the pharmacist had reviewed the medication orders on 6/11/13 with no recommendations.</p> <p>2.) Resident #48's clinical record was reviewed on 7/11/13 at 10:16 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and high cholesterol.</p> <p>The resident's current physician's orders were signed by the physician on 6/27/13. The resident had an</p>		<p>the contracted pharmacy was contacted and education was provided to the facility consultant pharmacist to include: Monitoring for adequate monitoring of Residents prescribed medications which require Blood Pressure and/or Pulse obtained prior to medication administration. Nursing staff were re-educated on medication administration and adequate monitoring of residents prescribed medications which require Blood Pressures and/or Pulse be obtained prior to administration of medication per physician order and care plan (see attachment C). The DON and/or designee will audit Medication Administration Records 5 xs weekly on scheduled work days to assure blood pressures and /or pulses obtained per physicians' orders and care plan (see attachment A). Should concerns be noted, corrective action shall be taken. The Consultant Pharmacist shall be responsible to also monitor for compliance during monthly drug regimen review, reporting any concerns with compliance to the physician and the Director of Nursing.4. As a means of quality assurance, The Nurse Consultant shall review/audit the physicians' orders of at least five residents monthly following the Consultant pharmacist medication regimen review, ongoing. Should irregularities be observed which were not identified by the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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>order for digoxin [a heart medication] 0.125 mg give 1 tablet by mouth every other day for atrial fibrillation.</p> <p>Review of the Medication Administration Records for May and June 2013, indicated the digoxin was given every other day as ordered. The records lacked an indication of the resident's pulse being monitored prior to the medication being administered.</p> <p>The "2010 Nursing Spectrum Drug Handbook" indicated the following as patient monitoring for digoxin: "Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber."</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's pulse had been taken prior to the administration of the medication.</p> <p>The clinical record indicated the pharmacist had reviewed the physician medication orders on 6/11/13 with no recommendations.</p> <p>3.) The clinical record for Resident #26 was reviewed on 7/11/13 at 2:17 p.m.</p>		<p>consultant pharmacist, the contracted pharmacy shall be notified in an effort to amend the corrective action accordingly. The Nurse consultant and the DON and/or designee will report the findings of these audits and any corrective actions taken to the Quality Assurance Committee monthly x 3 months and quarterly thereafter. Revisions will be made to the plan, if warranted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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>Diagnoses for Resident #26 included, but were not limited to, hypertension, diabetes, atrial fibrillation, and depression.</p> <p>A physician's order, dated 5/10/10, indicated Bystolic (a blood pressure medication) 10 milligrams (mg) 1 tablet by mouth every day. Hold medication if systolic blood pressure was less than 120.</p> <p>A physician's order dated 5/15/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 2 tablets by mouth every day for 4 days.</p> <p>A physician's order dated 5/20/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 1 tablet by mouth every day.</p> <p>The Medication Administration Record (MAR) for May 2013, indicated the blood pressure on 5/5/13 was 119/72, and on 5/27/13 the blood pressure was 106/59. The Bystolic had been given on both days.</p> <p>The June 2013, MAR indicated the blood pressure on 6/30/13, was 115/76. The Bystolic had been given on this date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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 May 2013, MAR indicated the resident started receiving the lanoxin on 5/16/13. No pulses were obtained from 5/16/13 to 5/31/16. The resident received the lanoxin 16 times in May.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 6/11/13, with no recommendations having been made for the Bystolic and the lanoxin orders.</p> <p>During an interview with the Director of Nursing on 7/12/13 at 10:35 a.m., additional information was requested related to the blood pressure and pulse monitoring before medication administration.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:03 a.m., she indicated any recommendations made by the pharmacist on 5/8/13, 6/11/13, and 7/11/13, were in the clinical record.</p> <p>The facility failed to provide any additional information as of exit on 7/15/13, at 3:15 p.m.</p> <p>3.1-25(i)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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 observation, record review, and interview, the facility failed to</p>	F000441	1. Resident 37 was assessed with no signs or symptoms of	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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>ensure the disinfecting wipes for cleaning the glucose meters were not expired for 1 of 1 observation of blood sugar monitoring. (LPN #1, Resident #37) This had the potential to effect 19 of 19 residents living in the building with orders for blood sugar monitoring.</p> <p>Findings include:</p> <p>An observation of LPN #1 testing Resident #37's blood sugar was made on 7/12/13 at 11:23 a.m. After obtaining the the blood sugar result, LPN #1 returned to the medication cart. She opened a packet of cleaning wipes, wiped the glucose meter, wrapped the glucose meter in the cleaning wipe, and set a timer for 5 minutes. The empty packet of the "Gluco-Chlor" disinfectant wipe used to clean the glucose meter was provided on 7/12/13 at 11:26 a.m. During review of the packet, it was noted the expiration date was 11/12.</p> <p>LPN #1 went to another medication cart and obtained a packet of disinfectant wipes. The expiration date on the packet was 12/12.</p> <p>The Director of Nursing was informed of the outdated wipes at 11:33 a.m. She indicated she did not know when</p>		<p>infection. Staff immediately obtained disinfectant wipes which were not outdated. Staff re-educated to assure supplies being used are checked for expiration dates prior to use, and no supplies are used past expiration dates (see attachment C).2. All other residents with the potential to be affected were assessed with no signs or symptoms of infection. Staff re-educated to assure that supplies being used are checked for expiration dates prior to use, and no supplies are used past expiration dates (see attachment C).3. Staff were re-educated concerning infection control and disposal of expired Nursing Supplies with expiration dates (see attachment C). The DON and/or designee will monitor Nursing Supplies 5 x / week x 4 weeks, 3 x / week x 4 weeks, and weekly thereafter, to assure there are no expired Nursing supplies (see attachment B) . Should concerns be observed, corrective action shall be taken.4. The DON and/or designee will report the findings of the audits and any corrective actions taken to the Quality Assurance Committee meetings monthly x 3 months then quarterly thereafter. Revisions will be made to the plan, if warranted.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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 wipes had been received. She indicated the facility had three medication carts and four blood glucose meters, two glucose meters for each hall. She also indicated, on 7/12/13 at 1:30 p.m., there were 19 residents whose blood glucose levels would be tested with these glucometers.</p> <p>During an interview with the Administrator and the Director of Nursing on 7/12/13 at 11:59 a.m., they indicated 17 boxes of wipes with the expiration dates of 11/12 and 12/12 had been removed from the supply room. They indicated these were the only wipes in the facility for cleaning the glucose meters.</p> <p>3.1-18(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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			
F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility's Quality Assessment and Assurance Committee failed to develop and implement plans of action to ensure expired supplies were not being used, blood pressures and pulses were being monitored before medication was being administered as ordered by physician and care planned, and irregularities were identified during monthly audits by the pharmacist.</p>	F000520	<p>1. Corrective actions as described in the Plan of Correction were taken for all residents relative to concerns of: expired supplies not being used, Blood pressures and pulses being monitored before medication was being administered as ordered by physician and care planned, and irregularities were not identified during monthly audits by the pharmacist.2. As many residents could be affected, the following corrective actions have been taken. Administrative staff has</p>	07/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(Resident #'s 63, 48, and 26)</p> <p>Findings include:</p> <p>1.) Resident #63's clinical record was reviewed on 7/11/13 at 9:05 a.m. The resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and severe aortic regurgitation.</p> <p>The resident had current physician's orders signed and dated by the physician on 5/15/13. The resident had an order for lisinopril [a blood pressure medication] 5 milligrams [mg] 1 tablet by mouth everyday and hold the medication if the systolic blood pressure was less than 115.</p> <p>Review of the Medication Administration Record for May of 2013, indicated the resident had received the lisinopril 5 mg every morning at 8:00 a.m., and lacked an indication of the blood pressure being obtained prior to the administration.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's blood pressure had been taken prior to the administration of the medication.</p>		<p>reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not be limited to concerns of expired supplies not being used, Blood pressures and pulses being monitored before medication was being administered as ordered by physician and care planned, and irregularities were not identified during monthly audits by the pharmacist (see attachments A, B).3. Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting audits to include but not be limited to concerns of expired supplies not being used, Blood pressures and pulses being monitored before medication was being administered as ordered by physician and care planned, and irregularities were not identified during monthly audits by the pharmacist. (see attachments A, B). Administration and/or Administrative nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care areas on concern and address with the Quality Assurance Committee in an effort to formulate an action plan should deficient practice be identified.4. As a means of Quality Assurance, The Administrator and/or designee and the DON and/or designee shall report the findings of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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 #48's clinical record was reviewed on 7/11/13 at 10:16 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and high cholesterol.</p> <p>The resident's current physician's orders were signed by the physician on 6/27/13. The resident had an order for digoxin [a heart medication] 0.125 mg 1 give 1 tablet by mouth every other day for atrial fibrillation.</p> <p>Review of the Medication Administration Records for May and June 2013, indicated the digoxin was given every other day as ordered. The records lacked an indication of the resident's pulse being monitored prior to the medication being administered.</p> <p>During an interview with the Director of Nursing on 7/15/13 at 11:00 a.m., she indicated she could not find any indication the resident's pulse had been taken prior to the administration of the medication.</p> <p>3.) The clinical record for Resident #26 was reviewed on 7/11/13 at 2:17 p.m.</p> <p>Diagnoses for Resident #26 included,</p>		<p>aforementioned audits and immediate corrective actions taken to the Quality Assurance Committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality of deficiencies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
(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>but were not limited to, hypertension, diabetes, atrial fibrillation, and depression.</p> <p>A physician's order, dated 5/10/10, indicated Bystolic (a blood pressure medication) 10 milligrams (mg) 1 tablet by mouth every day. Hold medication if systolic blood pressure was less than 120.</p> <p>A physician orders, dated 5/15/13 and 5/20/13, indicated lanoxin (a heart medication) 0.125 milligrams (mg) 2 tablets by mouth every day for 4 days then daily.</p> <p>The Medication Administration Record (MAR) for May 2013 indicated the blood pressure on 5/5/13 was 119/72, and on 5/27/13 the blood pressure was 106/59. The Bystolic had been given on both days.</p> <p>The June 2013 MAR indicated the blood pressure on 6/30/13 was 115/76. The Bystolic had been given on this date.</p> <p>The May 2013 MAR indicated the resident started receiving the lanoxin on 5/16/13. No pulses were obtained from 5/16/13 to 5/31/16. The resident received the lanoxin 16 times in May.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
---	---

(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 indicated the pharmacist reviewed the physician's orders on 6/11/13, with no recommendations having been made for the Bystolic and the lanoxin orders.</p> <p>4.) An observation of LPN #1 testing Resident #37's blood sugar was made on 7/12/13 at 11:23 a.m. After obtaining the the blood sugar result, LPN #1 returned to the medication cart. She opened a packet of cleaning wipes, wiped the glucose meter, wrapped the glucose meter in the cleaning wipe, and set a timer for 5 minutes. The empty packet of the "Gluco-Chlor" disinfectant wipe used to clean the glucose meter was provided on 7/12/13 at 11:26 a.m. During review of the packet it was noted the expiration date was 11/12.</p> <p>LPN #1 went to another medication cart and obtained a packet of disinfectant wipes. The expiration date on the packet was 12/12.</p> <p>5.) During an interview with the Administrator on 7/15/13 at 1:33 p.m., she indicated the facility had failed to identify the concerns with expired supplies, the monitoring of blood pressures and pulses per physician orders and the care plan, and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2013
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394		
(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>pharmacist not identifying irregularities during monthly audits.</p> <p>3.1-52(b)(2)</p>				