

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 09/11/2012
--	---	--	---

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
F0000	<p>This visit was for the Investigation of Complaints IN00114426, IN00115023, IN00115545, and IN00115975.</p> <p>Complaint IN00114426 - Substantiated. Federal/state deficiencies related to the allegations are cited at F425 and F431.</p> <p>Complaint IN00115023 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00115545 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F490.</p> <p>Complaint IN00115975 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: September 10 and 11, 2012</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Diana Sidell RN, TC Cheryl Fielden RN</p>	F0000		

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 09/11/2012
--	---	--	---

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>Census bed type: SNF/NF: 117 Total: 117</p> <p>Census payor type: Medicare: 14 Medicaid: 91 Other: 12 Total: 117</p> <p>Sample: 14</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/18/12 Cathy Emswiller 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 09/11/2012	
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			
F0223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure residents remained free from abuse and misappropriation of funds in that one incident of staff to resident verbal and physical abuse occurred in the facility, and one incident of resident misappropriation of funds occurred in the facility. This affected 2 of 3 reportable incidents reviewed for abuse in a sample of 3. (Resident #0 and #P)</p> <p>Findings include:</p> <p>1. Resident #P's "Unusual Occurrence Report" was reviewed on 9/11/12 at 2:30 p.m. The report indicated Resident #P's diagnoses included but were not limited to: dementia with behavior disturbance.</p> <p>A quarterly minimum data set assessment (MDS), dated 8/16/12, indicated Resident #P was severely impaired.</p>	F0223	<p>F 0223</p> <p>1.Regarding resident P, resident was assessed for injuries. None were noted. Regarding resident O, all items and monies were returned to him. The local authorities were notified of both incidents.</p> <p>2.All residents are at risk. Staff in service conducted after each incident.</p> <p>3.Staff in serviced on 8/31/2012 on abuse and misappropriation of resident funds. Social Services/designee will randomly interview residents to ensure safety/well being weekly. (ongoing)</p> <p>4.Social Services/designee will QA resident interviews and present during monthly QA meetings. Any findings will be addressed immediately and reported accordingly.</p>	10/11/2012			

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 09/11/2012	
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 facility report titled "Unusual Occurrence Report" was submitted by email on 8/23/12 at 7:45 a.m., to ISDH (Indiana State Department of Health). The report indicated but was not limited to: "Brief Description of Incident: On the morning of 8/23/12, (LPN #1) was in the activity room with (Resident #P) and other residents, as preparations were being made for breakfast. (CNA #2) entered the room to deliver a tray for another resident when agitation between (Resident #P) and (resident) was observed. (CNA #2) then went to (Resident #P), took him under the arm ...said "damm it," then roughly took (Resident #P) to the couch to be seated. (CNA #2) was observed by both (LPN #1) and (LPN #2), to be agitated herself during redirection and afterwards. Immediate Action Taken: (CNA #2) was escorted from the building and suspended pending outcome of investigation. (Resident #P) was checked for any injuries and per SSD (Social Services Director) follow-up had no apparent recall of incident nor fear as a result. Family, physician, and local police notified. Preventative measure taken: Immediate re-inservicing of Dementia unit staff on abuse and neglect conducted further all staff re-inservicing planned for 8-31-12. SSD interviewed various residents who could have had contact with (CNA #2) to</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 09/11/2012
--	---	--	---

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 assure well-being of residents as a whole (no other issues discovered). Interviewed all parties involved with the incident. Concluded that (CNA #2) would be terminated due to her actions. Police report completed [Case Number Documented]. Psych follow-up planned for (Resident #P) as precaution to assure well-being. No further reporting to be expected. "</p> <p>Local Police Department notified on 8/23/12, no time noted, regarding Resident #O's abuse by (CNA #2). Police report [Case Number Documented] filed.</p> <p>An all staff inservice on abuse and neglect conducted on 8/31/12, no time noted.</p> <p>2. Resident #O's "Unusual Occurrence Report" was reviewed on 9/11/12 at 2:45 p.m. The report indicated Resident #O's diagnoses included but were not limited to: chronic kidney disease, anemia, and diabetes.</p> <p>A quarterly minimum data set assessment (MDS); dated 8/13/12, indicated Resident #O was cognitively intact.</p> <p>A facility "Unusual Occurrence Report" was submitted by email on 8/28/12 at 10:42 p.m., to ISDH (Indiana State Department of Health). The report</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 09/11/2012
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 but was not limited to: "Brief Description of Incident: On 8/27/12, Resident #O inquired as to why he had not seen (CNA #1) in a few days. When told that (CNA #1) no longer works for the facility (terminated ...for unrelated issues) he stated (CNA #1) owes him \$123.00 and wanted money deducted from (CNA #1) paycheck. Upon follow-up with Resident #O, he reported that on weekend of July 7th (2012), he had given (CNA #1) \$50.00 to order him two books from the internet. He then gave (CNA #1) another \$50.00 around Aug, 20th for purchase of some pens, paper, and candy. In addition, he said he gave (CNA #1) \$23.00 in one dollar bills but could not remember the date of this. For all the money he gave (CNA #1)...only brought in a couple of cases of pop. He stated (CNA #1) gave him excuses as to why...didn't bring in items or monies and that he felt sorry for...Immediate Action Taken: SSD (Social Service Director) educated (Resident #O) on only giving money to designated shopper (activity director) for any purchases and reminded him that it would be in his best interest to keep his monies in a resident trust-but he declined. (CNA #1) was contacted to bring in money and/or items...only brought in a couple of pens and a notepad without a receipt. North Vernon Police contacted</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 09/11/2012
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 reported. As stated before, (CNA #1) was already terminated from the facility at time of report for unrelated issues. All staff inservice on misappropriation of resident belongings planned for 8-31-12. Will also be addressed with Resident council on 8/31/12 to advice residents not to give staff money for any reason unless activity director scheduled shopping."</p> <p>A typed statement provided by the Administrator and dated 9/11/12 indicated "Referencing the incident from 8/27/12 concerning (Resident #O), Jennings Healthcare ordered the books for (Resident #O) that he requested from (CNA #1). These two books arrived on 9/10/12 and were given to (Resident #O) by (Resident #L)..., in addition the facility reimbursed (Resident #O) the \$23.00 that he gave (CNA #1).</p> <p>Local Police Department notified on 8/27/12, no time noted, regarding Resident #O's misappropriation of funds by (CNA #1). Police report filed, number of report not provided.</p> <p>An all staff inservice conducted on 8/31/12 regarding misappropriation of funds.</p> <p>Information regarding the misappropriation of funds presented to</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 09/11/2012
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 resident council meeting on 8/31/12.</p> <p>The Policy and Procedure titled "Resident Abuse" and received on 9/10/12 at 7:58 a.m., from the Administrator, with an effective date of 03/12. The policy indicated: "...the right to be free from abuse, neglect...misappropriation of property. Employees...are charged with a continuing obligation to treat residents so they are free from abuse, neglect...misappropriation of property....No employee may at any time commit an act of physical, psychological or emotional abuse...misappropriation of property against any resident. Violation of this standard will subject the employees to disciplinary action, including dismissal..."</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(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 09/11/2012
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	
F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record review and interview, the facility failed to ensure a resident received appropriate treatment and services to maintain or improve bowel function in that 1 resident had multiple documented days of no bowel movements, was admitted to the hospital with a diagnoses of fecal impaction, and returned to the facility where she did not receive a physician's ordered enema. This affected 1 of 3 residents reviewed for bowel management. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed on 9/10/12 at 10:20 a.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease with sudden worsening, congestive heart failure, high blood pressure, restless leg syndrome, chronic kidney disease, major depressive disorder, recurrent with psychosis, osteoarthritis,</p>	F0309	<p>- F 309 SS=G Provide Care/Services for Highest Well being</p> <ol style="list-style-type: none"> 1.Resident D no longer resides in the facility. 2.Residents were reviewed for bowel function by the nurse management team to determine bowel function and factors that could lead to constipation. Care plans were reviewed and revised as indicated. 3.Licensed staff will be re educated on bowel management and documentation by the DOCS/Designee. Non licensed staff will be re educated by the DOCS/Designee on the importance of documentation of bowel movement and reporting accordingly. Bowel records will be reviewed by in the IDT in Daily Clinical meeting to ensure residents bowel functions is maintained. Any variances will be addressed immediately. 4.The DOCS/Designee will review bowel records daily for 30 days then weekly for three months and then monthly 	10/11/2012	

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 09/11/2012
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 constipation.</p> <p>A quarterly Minimum Data Set assessment dated 4/16/12 indicated Resident #D was severely impaired in cognitive skills for daily decision making, was dependent on two staff for toileting, and was usually incontinent of bowel and bladder.</p> <p>A care plan with a start date of 5/31/11, and a last review date of 8/17/12, indicated a problem need for "Constipation r/t (related to) [decreased] fluid intake, [decreased] fiber intake, and [decreased] mobility. Goals: Resident will have a BM (bowel movement) no less than every 3 days. Approaches: 1) MOM (milk of magnesia) 30 cc (cubic centimeters) po (by mouth) qd (every day) prn (as needed) 2) Dulcolax Supp[ository] 10 mg (milligrams) PR (per rectum) qd prn for no BM in 3 days 3) Encourage activity w(with)/in tolerance 4) encourage fluids, DSS (docusate sodium) to 200 mg QD Senna [1] QHS. (6/10/11)"</p> <p>Physician's monthly recapitulation orders dated 7/2012 indicated these routine medications to prevent constipation: "Docusate sodium 100 mg capsule, give 2 capsules (200mg) orally once a day" with a start date of 7/22/11, and "Senna Laxative 8.6 mg tablet, give 1 tablet</p>		(ongoing). Any findings will be brought to QA for review with a revised action plan to follow if indicated. 5.10/11/2012		

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 09/11/2012
--	---	--	---

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>orally daily at bedtime" with a start date of 7/22/11.</p> <p>Physician's monthly recapitulation orders dated 7/2012 also included these as needed medications to relieve constipation: "Bisacodyl 10 mg suppository, insert 1 suppository rectally daily prn for no BM X 3 days" and "Milk of magnesia susp[ension], give 30 ml (milliliters) orally once a day prn for constipation" and both had start dates of 7/22/11.</p> <p>Medication administration records (MARs) dated 6/2012 indicated documentation that the Senna Laxative had been given every day, and the Docusate sodium had been given every day except one, on 6/29. The MARs also included documentation a Bisacodyl 10 mg suppository had been given on 6/12 with results of "+" (positive), and 30 cc's of Milk of magnesia had been given on 6/5 with results of "eff" (effective), 6/18, 6/20, and 6/23, with results of "+".</p> <p>MARs dated 7/2012 indicated documentation that the Senna laxative had been given every day between 7/1 and 7/14, except for 7/1, 7/2, and 7/12. The Docusate sodium was documented as given every day between 7/1 and 7/14. Milk of magnesia had been given on 7/9,</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 09/11/2012
--	---	--	---

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>with no results, and on 7/10, 7/12 with no results documented.</p> <p>A "Bowel and Bladder Chart Detail Report" indicated Resident #D was incontinent of a medium BM on 6/30/12, then did not have any documented bowel movements until a small BM on 7/11/12. There were no documented BM's until a medium BM on 7/13/12.</p> <p>Nurse's progress notes dated 7/14/12 at 9:00 a.m. indicated: "Resident not responding to staff. Vitals 106/72 62 (pulse) - 18 (respirations) O2 (oxygen) sat[uration] 96% temp 97.8. O2 on at 2L (liters)."</p> <p>Nurse's progress notes dated 7/14/12 at 11:00 a.m. indicated: "Resident still not responding held valium and other pills. Resident unable to take in fluids & not voiding. [Nurse practitioner] into see Resident at this time O2 sat 86% HR 124. She ordered Resident to be seen at [local hospital]. Res. prepared for transfer report called to [local hospital]."</p> <p>An "Emergency Nursing Record" from the local hospital indicated Resident #D was examined in the emergency department and then returned to the nursing home with new diagnoses of dehydration and fecal impaction.</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 09/11/2012
--	---	--	---

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 CT scan of the abdomen was done for complaints of abdominal pain. The results of the CT scan indicated, but was not limited to "... There is a large amount of stool throughout the colon. The rectum is distended and measures 9 cm (centimeters) in diameter. No distended small bowel loops are seen...Impression: 1. Fecal impaction. 2. 4.5 cm abdominal aortic aneurysm without evidence of leak...."</p> <p>Physician's orders from the emergency room, dated 7/14/12 at 5:30 p.m., indicated: "Return to ECF, Dx dehydration, fecal impaction. IVF .9NS @ 100 cc/hrX24 [hours], Soap suds enema tonite...."</p> <p>Nurse's progress notes dated 7/14/12 at 6:15 p.m. indicated: "Res. returned to facility via ambulance from [local hospital] E.R. N.O.'s received and noted. Res awake but non-verbal. BP 110/60 p 58 R 18 T 97.7 O2 sat[uration] 93%. O2 per N/C @ 2 lpm (liters per minute). Returned [with] L) wrist SL (saline lock). Area [without] s/s (signs and symptoms) [of infection] or infiltrate. N.S. (normal saline) IV (intravenous) fluids @ 100 ml/hr cont[inues] Denies pain. [No] s/s acute distress."</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 09/11/2012
--	---	--	---

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>Nurse's progress noted dated 7/14/12 at 11:45 p.m. indicated: "Refused SVN (small volume nebulizer) - Tx (treatment) @ this time. States "no, not now".</p> <p>Nurse's progress notes dated 7/15/12 at 12:25 a.m. indicated: "CNA called this nurse to room. Upon entering room res was cyanotic. [No] pulse [no] resp[irations]. CPR started @ this time and 911 called."</p> <p>Nurse's progress notes dated 7/15/12 at 1:00 a.m. indicated: "Transferred to hosp[ital] per amb[ulance] via stretcher (CPR cont)."</p> <p>Emergency Room narrative notes, dated 7/15/12, indicated Resident #D's time of death was 1:11 p.m. and that CPR and medications had been administered. The narrative included: "...called [name of] Coroner, per [name of Coroner] pt (patient) is not to be a Coroner's case...."</p> <p>During an interview on 9/11/12 at 6:30 p.m., the Director of Clinical Services indicated the soap suds enema was not given after the resident returned from the hospital because the nurse was concerned about giving the soap suds enema and overloading the resident with additional fluids.</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 09/11/2012
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 9/11/12 at 1:30 p.m., the Director of Clinical Services and the Administrator indicated they did not have a policy and procedure for Bowel Management. They said they use nursing practice, they follow the bowel sheets and watch for trends or alerts if the resident has not had a BM for greater than 72 hours, they go by the nursing assessments - what bowel sounds are like, and if the abdomen is tender.</p> <p>This Federal tag relates to Complaint IN00115545.</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 09/11/2012
--	---	--	---

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
F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, record review, and interview, the facility failed to provide pharmaceutical services that included the disposition of medications in that discontinued or outdated medications were found stored on a medication room shelf, and not destroyed for 1 of 1 medication rooms, 1 of 1 observations and 23 residents. (Residents #U, V, W, X, D, Z, AA, CC, DD, EE, FF, GG, R, II, JJ, KK, LL, MM, Q, OO, PP, S,</p> <p>Findings include:</p>	F0425	<p>F 425 SS=EPharmaceutical SVC Accurate Procedures,RPH1. There was no negative outcome. Regarding residents U,V,W,X,D,Z,AA,CC,DD,EE,GG, R,II,JJ,KK,LL,MM,Q,OO,PP,S, Outdated medications were destroyed. 2. Resident medication has been reviewed for accuracy relating to expiration date. Any findings were addressed. Medications for discharged residents were destroyed. Licensed staff was re educated on facility Policy and Procedure regarding expired medications and or discontinued medications.3. The Unit Manager will perform random medication</p>	10/11/2012

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 09/11/2012	
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 9/11/12, beginning at 10:18 a.m., with LPN #3, the following medications were observed in a cabinet in the locked medication room and had not been destroyed after a resident was discharged or the medication discontinued:</p> <ul style="list-style-type: none"> - 7 lidoderm 5% patches for Resident #U, discharged on 6/25/12 - 24 packets of Ipratropium/albuterol unit dose packets for nebulizer treatments, for Resident #V, discharged on 7/14/12 - Novolog flex pens, 4 in the box, for Resident #V, discharged on 7/14/12 - 1/2 bottle of multivitamins for Resident #W, discharged on 8/30/12 - 2 full, unopened vials of Lantus insulin for Resident #X, discharged on 8/2/12 - 1 full bottle of loperamide, 24 in the bottle, for Resident #W, discharged on 8/30/12 - 1 unopened vial of Novolog insulin for Resident #V, discharged on 7/14/12 - 4 Bisacodyl suppositories, 10 milligrams (mg), for Resident #D, discharged on 7/15/12 - 10 Tylenol suppositories, 650 mg for Resident #Z, discharged on 9/1/12 - 2 boxes of 10 phenergan suppositories, 25 mg, for Resident #AA, discharged on 8/26/12 - 1 bottle of Fluticasone nasal spray, for Resident #W, discharged on 8/30/12 - 3 tables Simvastatin, 40 mg, for 		<p>cart audits daily for expired medications, the medication destruction sheets and or /return to pharmacy sheets per policy and procedure. 4. The DOCS/Designee will audit medication room and medication carts daily for one week then weekly for three months then monthly (ongoing). The results of these audits will be reviewed in monthly QA meetings.</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 09/11/2012
--	---	--	---

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>Resident #CC, who had an order change</p> <ul style="list-style-type: none"> - 30 Las tablets, 20 mg for Resident #V, discharged on 7/14/12 - 45 tablets Lexapro, 20 mg, for Resident #CC, who had an order change - 1/2 bottle Detrol LA, 4 mg, for Resident #CC, who had an order change - 1 full bottle of Natural Tears, for Resident #CC, who had an order change - 1 bottle of 20 Lexapro, 10 mg, for Resident #CC, who had an order change - 1 full bottle of Detrol LA, 4 mg, for Resident #CC, who had an order change - 1/2 bottle of Pancrealipase, for Resident #DD, discharged on 9/4/12 - 12 tablets Prednisone, 10 mg, for Resident #Z, discharged on 9/1/12 - 20 Omeprazole, 20 mg, for Resident #EE, who had an order change - 3 1/2 packets of Albuterol Sulfate inhalation solution, 0.008% for nebulizer treatments, for Resident #FF, who was discharged on 8/30/12 - 5 packets of Albuterol Sulfate inhalation solution, 0.008% for nebulizer treatments, for Resident #GG, who had an order change - 5 Baclofen tablets, 10 mg, for Resident #R who had an order change - An unopened box of promethazine tablets, 25 mg, 30 in the box, for Resident #II who had an order change - 3 bottles of 25 each of Nitrostat 0.4 mg, for Resident JJ, the medication had 			

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 09/11/2012
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>expired.</p> <ul style="list-style-type: none"> - 3 ounces (in a 4 ounce bottle) of Robafen cough syrup, for Resident KK, the order had expired - 1 tube of Bacitracin ointment, for Resident LL, the order had expired - 220 milliliters in a 240 ml bottle of Mary's Magic Mouthwash, for Resident #MM, the order had expired - 1/2 tube Triamcinalone 0.025% cream, for Resident #Q who had an order change - 1/2 vial Lantus insulin for Resident #OO, the medication had expired - 1/2 tube Bacitracin ophthalmic ointment for Resident #PP, the order had expired - 1/2 bottle Apisol, with a sticker that indicated "do not use after 8/19/12 - 1 full bottle of ear drops for Resident #S, the order had expired - 1 vial of Novolog insulin 60% full, and 1 vial Novolog with no box, and no opened date for Resident #KK, the insulin had expired on 8/15/12 - 1 bottle of nitroglycerin tablets, the name was smudged and illegible, with a sticker that indicated: "This medication is expired and has been removed by your Pharmacy QA Technician, PLEASE DESTROY." <p>During an interview on 9/11/12 at 9:36 a.m., LPN #1 indicated that when a medication is changed, the nurse is supposed to destroy it or return it to the</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 09/11/2012	
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>pharmacy. If returned to the pharmacy, they scan it and place it in a container for pharmacy to pick up, it has to be refrigerated, they place it on ice packs. If they destroy it, they place it in coffee grounds to dissolve. LPN #1 also indicated the pharmacist was here on 8/21/12 and had removed the outdated medications from the med carts.</p> <p>A policy and procedure for "Medication Destruction", with a last review date of 3/13/12, was provided by the Assistant Director of Clinical Services on 9/11/12 at 5:20 p.m. The policy indicated, but was not limited to: "Policy: Discontinued medications and medications left in the facility after a resident's discharge if not returned for credit are destroyed in the facility. Procedure: 1. Unused portions of any medication/treatment which cannot be returned to pharmacy are to be destroyed in the facility when the medication is discontinued, expired, or the resident has been discharge without medication or the resident has expired...3. Ointments, creams, and similar substances are placed in a trash receptacle in the medication room...6. The nurses or pharmacist witnessing the destruction ensures that the following information is entered on the medication disposition form within seven (7) days of the discontinuation: A. 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 09/11/2012
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>of destruction B. Resident's name C. Name and strength of medication D. Prescription number E. Amount destroyed F. Signatures of witnesses G. Reason for disposal H. Method of disposal...."</p> <p>This Federal tag relates to Complaint IN00114426.</p> <p>3.1-25(o) 3.1-25(r)</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 09/11/2012	
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			
F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure insulin was dated when opened for 1 of 3</p>	F0431	<p>F 431 SS=E Drug Records Labels/Store Drugs & Biologicals</p> <p>1.Regarding residents B and QQ, medication was removed</p>	10/11/2012			

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 09/11/2012
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>medication cart observations in 1 of 7 medication carts, for 2 residents (Residents #B and QQ) , and further failed to ensure outdated insulin had been removed from the medication carts for 3 of 3 medication cart observations in 3 of 7 medication carts, and 6 residents. (Residents #C, RR, Q, O, R, and T)</p> <p>Findings include:</p> <p>During an observation on 9/11/12 at 9:45 a.m., of the 'A' hall medication cart, with LPN # 4, the following medications were observed that did not have a date on the bottle, or box, as when it was opened:</p> <ul style="list-style-type: none"> - An opened bottle of Novolog insulin 100 units/milliliter (ml), for Resident #B. - An opened bottle of Levemir Insulin 100 units/ml, for Resident #QQ. - An opened bottle of Humalog Insulin 100 units/ml, for Resident #QQ. <p>During an observation on 9/11/12 at 9:45 a.m., of the 'A' hall medication cart, with LPN # 4, the following medications were observed that were outdated:</p> <ul style="list-style-type: none"> - An opened vial of Lantus insulin 100 units/ml, for Resident #C, the 'date opened' sticker indicated 8/5/12, and the 'do not use after' sticker was dated 9/2/12. - An opened vial of Novolog insulin 100 units/ml, for Resident #C, the 'date opened' sticker indicated 8/5/12, and the 		<p>from the medication cart, destroyed and re ordered. There was no negative outcome. Regarding residents C,RR,Q,O,R and T, medication was removed from the medication cart, destroyed and reordered. There was no negative outcome.</p> <p>2.Residents medication has been reviewed for accuracy relating to expiration date. Any findings were addressed. All medications for discharged residents were destroyed.</p> <p>3.All licensed staff was re educated on facility Policy and Procedure regarding expired medications and or discontinued medications.</p> <p>4.The Unit Manager will perform random medication cart audits daily for expired medications, the medication destruction sheets and or /return to pharmacy sheets per policy and procedure. The DOCS/Designee will audit medication room and medication carts daily for one week then weekly for three months then monthly (ongoing). The results of these audits will be reviewed in monthly QA meetings.</p> <p>5.10/11/12</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 09/11/2012
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>'do not use after' sticker was dated 9/2/12.</p> <p>During an observation on 9/11/12 at 10:15 a.m., on the 'B' hall medication cart, with RN#1, the following medications were observed that were outdated: - Novolog insulin 100 units/ml, for Resident RR, the 'date opened' sticker was dated 7/25/12, and the 'do not use after' sticker was dated 8/22/12.</p> <p>During an observation on 9/11/12 at 9:47 a.m., on the 'C' hall medication cart, with LPN #3, the following medications were observed that were outdated: - Novolog insulin 100 units/ml, for Resident #Q, the 'date opened' sticker was dated 7/10/12, and the 'do not use after' sticker was dated 8/7/12. - Novolog insulin 100 units/ml, for Resident #O, the 'date opened' sticker was dated 7/22/12 and the 'do not use after' sticker was dated 8/9/12. - Lantus insulin 100 units/ml, for Resident #R, the 'date opened' sticker was dated 8/7/12, and the 'do not use after' sticker was dated 9/4/12. - Lantus insulin 100 units/ml, for Resident #T, the 'date opened sticker was dated 7/26/12, and the 'do not use after' sticker was dated 8/25/12.</p> <p>During an interview on 9/11/12 at 9/36 a.m., LPN #1 indicated the pharmacist</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 09/11/2012
--	---	--	---

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>was here on 8/21/12 and had removed the outdated medications from the med carts.</p> <p>A policy and procedure for "Expiration dates and compromised medication", with a last review date of 3/13/12, was provided by RN #1 on 9/11/12 at 10:30 a.m. The policy indicated, but was not limited to: "Expiration dates assure the adequate potency and effectiveness of medications. Only medication with intact integrity should be administered to a resident..."</p> <p>This Federal tag relates to Complaint IN00114426.</p> <p>3.1-25(r)</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 09/11/2012
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	
F0490 SS=F	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to develop written policies and procedures regarding bowel management in that 1 resident had multiple days of no bowel movements, was sent to the hospital and returned with a diagnoses of fecal impaction. This deficient practice has the potential to affect all 117 residents residing in the facility. (Resident #D)</p> <p>Finding include:</p> <p>Resident #D's record was reviewed on 9/10/12 at 10:20 a.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease with sudden worsening, congestive heart failure, high blood pressure, restless leg syndrome, chronic kidney disease, major depressive disorder, recurrent with psychosis, osteoarthritis, and constipation.</p> <p>A quarterly Minimum Data Set</p>	F0490	<p>F 490 SS=F Administration/Resident well Being</p> <ol style="list-style-type: none"> 1.Resident D no longer resides in the facility. 2.Residents were reviewed for bowel function by the nurse management team to determine bowel function and factors that could lead to constipation. Care plans were reviewed and revised as indicated. 3.Licensed staff will be re educated on bowel management and documentation by the DOCS/Designee. Non licensed staff will be re educated by the DOCS/Designee on the importance of documentation of bowel movement and reporting accordingly. Bowel records will be reviewed by in the IDT in Daily Clinical meeting to ensure residents bowel functions is maintained. Any variances will be addressed immediately. 4.The DOCS/Designee will review bowel records daily for 30 days then weekly for three months and then monthly (ongoing). Any findings will be brought to QA for review with a revised action plan to follow if indicated. 	10/11/2012	

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 09/11/2012
--	---	--	---

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>assessment dated 4/16/12 indicated Resident #D was severely impaired in cognitive skills for daily decision making, was dependent on two staff for toileting, and was usually incontinent of bowel and bladder.</p> <p>A care plan with a start date of 5/31/11, and a last review date of 8/17/12, indicated a problem need for "Constipation r/t (related to) [decreased] fluid intake, [decreased] fiber intake, and [decreased] mobility. Goals: Resident will have a BM (bowel movement) no less than every 3 days. Approaches: 1) MOM (milk of magnesia) 30 cc (cubic centimeters) po (by mouth) qd (every day) prn (as needed) 2) Dulcolax Supp[ository] 10 mg (milligrams) PR (per rectum) qd prn for no BM in 3 days 3) Encourage activity w(with)/in tolerance 4) encourage fluids, DSS (docusate sodium) to 200 mg QD Senna [1] QHS. (6/10/11)."</p> <p>Physician's monthly recapitulation orders dated 7/2012 indicated these routine medications to prevent constipation: "Docusate sodium 100 mg capsule, give 2 capsules (200mg) orally once a day" with a start date of 7/22/11, and "Senna Laxative 8.6 mg tablet, give 1 tablet orally daily at bedtime" with a start date of 7/22/11."</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 09/11/2012	
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>Physician's monthly recapitulation orders dated 7/2012 also included these as needed medications to relieve constipation: "Bisacodyl 10 mg suppository, insert 1 suppository rectally daily prn for no BM X 3 days" and "Milk of magnesia susp[ension], give 30 ml (milliliters) orally once a day prn for constipation", and both had start dates of 7/22/11.</p> <p>Medication administration records (MARs) dated 6/2012 indicated documentation that the Senna Laxative had been given every day, and the Docusate Sodium had been given every day except one, on 6/29. The MARs also included documentation a Bisacodyl 10 mg suppository had been given on 6/12 with results of "+" (positive), and 30 cc's of Milk of magnesia had been given on 6/5 with results of "eff" (effective), 6/18, 6/20, and 6/23, with results of "+".</p> <p>MARs dated 7/2012 indicated documentation that the Senna laxative had been given every day between 7/1 and 7/14, except for 7/1, 7/2, and 7/12. The Docusate sodium was documented as given every day between 7/1 and 7/14. Milk of magnesia had been given on 7/9, with no results, and on 7/10, 7/12 with no results documented.</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 09/11/2012
--	---	--	---

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 "Bowel and Bladder Chart Detail Report" indicated Resident #D was incontinent of a medium BM on 6/30/12, then did not have any documented bowel movements until a small BM on 7/11/12. There were no documented BM's until a medium BM on 7/13/12.</p> <p>Nurse's progress notes dated 7/14/12 at 9:00 a.m. indicated: "Resident not responding to staff. Vitals 106/72 62 (pulse) - 18 (respirations) O2 (oxygen) sat[uration] 96% temp 97.8. O2 on at 2L (liters)."</p> <p>Nurse's progress notes dated 7/14/12 at 11:00 a.m. indicated: "Resident still not responding held valium and other pills. Resident unable to take in fluids & not voiding. [Nurse practitioner] in to see Resident at this time O2 sat 86% HR 124. She ordered Resident to be seen at [local hospital]. Res. prepared for transfer report called to [local hospital]."</p> <p>An "Emergency Nursing Record" from the local hospital indicated Resident #D was examined in the emergency department on 7/14/12 at 11:53 a.m., then returned to the nursing home with new diagnoses of dehydration and fecal impaction.</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 09/11/2012
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 CT scan of the abdomen was done for complaints of abdominal pain. The results of the CT scan indicated, but was not limited to "... There is a large amount of stool throughout the colon. The rectum is distended and measures 9 cm (centimeters) in diameter. No distended small bowel loops are seen...Impression: 1. Fecal impaction..."</p> <p>Nurse's progress notes dated 7/15/12 at 12:25 a.m. indicated: "CNA called this nurse to room. Upon entering room res was cyanotic. [No] pulse [no] resp[irations]. CPR started @ this time and 911 called."</p> <p>Nurse's progress notes dated 7/15/12 at 1:00 a.m. indicated: "Transferred to hosp[ital] per amb[ulance] via stretcher (CPR cont)."</p> <p>During an interview on 9/11/12 at 6:30 p.m., the Director of Clinical Services indicated the soap suds enema was not given after the resident returned from the hospital because the nurse was concerned about giving the soap suds enema and overloading the resident with additional fluids.</p> <p>On 9/11/12 at 1:30 p.m., the Director of Clinical Services and the Administrator indicated they did not have a policy and</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 09/11/2012
--	---	--	---

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>procedure for Bowel Management; they use nursing practice, they follow the bowel sheets and watch for trends or alerts every 72 hours, they go by the nursing assessments - what bowel sounds are like, if the abdomen is tender, if the resident has not had a BM, or if they have diarrhea, or if they are vomiting.</p> <p>This Federal tag relates to Complaint IN00115545.</p> <p>3.1-13(q)</p>			