

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/09/2015
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NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00174411.</p> <p>Complaint IN00174411 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F282.</p> <p>Survey date: June 8 and 9, 2015</p> <p>Facility number: 000388 Provider number: 155807 AIM number: 100454140</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census Payor type: Medicare: 2 Medicaid: 40 Other: 2 Total: 44</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This plan of correction is to serve as Rural Health Care's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rural Health Care or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of compliance of the nursing care or the other services in the facility. Nor does this submission constitute an admission or agreement of the survey allegations.</p>	
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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.

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record, the</p>	F 0157	I. The physician was notified of	06/23/2015			

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	<p>facility failed to notify the Physician of a Resident's consistent refusal of gastronomy/jejunum tube (G/J-tube) flushes for 1 of 3 Residents reviewed for tube feedings. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 6/9/15 at 9:35 a.m. The diagnoses for Resident #D included, but were not limited to, severe dysphasia, encephalopathy, and debility.</p> <p>The May and June 2015 Physician's Orders indicated an order to flush the Resident's G/J-tube with 50 milliliters of water at 2:00 a.m. and 10 p.m.</p> <p>The May and June 2015 MAR (medication administration record) indicated Resident #D refused the G/J flush by LPN #3 on the following days: 5/2/15 x 2 (time indecipherable), 5/3/15 (no time listed), 5/4/15 (no time listed), 5/5/15 (no time listed), 5/7/15 (no time listed), 5/8/15 (no time listed), 5/12/15 (no time listed), 5/14/15 (no time listed), 5/15/15 (no time listed), 5/16/15 (no time listed), 5/17/15 (no time listed),</p>		<p>the resident's refusal of g-tube flush to see if new orders were necessary. II. Two residents have the potential to be effected by the deficient practice. III. All nurses were educated on what is defined of a refusal of treatment and to notify the physician immediately when it occurs. IV. The IDT will audit nurse's notes daily to verify that if a refusal of treatment occurs that the physician is notified so that he can determine if new orders need to be written. V. Audits of MAR will occur three times a week for one month, one time per week for one month then monthly.</p>	

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	<p>5/18/15 (no time listed), 5/19/15 (no time listed), 5/21/15 (no time listed), 5/23/15 (no time listed), 5/26/15 (no time listed), 5/28/15 (no time listed), 5/29/15 (no time listed), 5/30/15 (no time listed), 6/1/15 (time indecipherable), 6/2/15 (no time listed), 6/3/15 (no time listed), 6/4/15 (no time listed), &amp; 6/5/15 (no time listed).</p> <p>The following Nurse's Notes indicated the following: 5/26/15, time indecipherable, "Refusal to allow G/J-tube flushes by writer continues....", 5/28/15, time indecipherable, " Refusal to allow writer to flush G/J-tube continues....," 5/29/15, time indecipherable, " Continues to refused [sic] to allow G/J-tube flush by writer....," 5/30/15 at 1:55 a.m., "Continues to be agitated when writer in in his room &amp; refuses GT [G-tube] flush by writer....," 6/1/15 at 2:20 a.m., "Refusal to allow writer to flush G/J-tube continues....," 6/3/15 at 2:20 a.m., "Refusal to allow writer to flush G/J-tube continues...."</p> <p>Physician notification of the refusal of</p>			

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	<p>above G/J-tube flushes was not located in the clinical record.</p> <p>During an interview with LPN #4, on 6/9/15 at 11:05 a.m., LPN #4 indicated LPN #3 should've notified the Physician of Resident #D's refusal of G/J flushes after 3 refusals. LPN #4 further indicated if the Physician was notified, the notification should be documented somewhere in the clinical record.</p> <p>On 6/9/15 at 11:24 a.m., the Assistant Director of Nursing (ADON) indicated Resident #D's G/J-tube was flushed to remain patent (open). The ADON further indicated the facility was unable to locate any documentation that the Physician was notified of the refusal of the G/J-tube flushes. The ADON indicated he will notify the Physician now.</p> <p>A policy titled, Change in a Resident's Condition or Status, 4/2012, was received from the ADON on 6/9/15 at 12:13 p.m. The policy indicated, "...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...g. Refusal of treatment or medication (i.e., two (2) or more consecutive times)...."</p> <p>This Federal Tag relates to Complaint #IN00174411.</p>			

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F 0282 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to treat a resident's skin condition, as ordered, for 1 of 3 residents reviewed for infections. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/8/15 at 11:30 a.m. The diagnoses for Resident #B included, but were not limited to: history of cerebral vascular accident, seizure disorder, and cerebral palsy.</p> <p>The 5/28/15, 2:52 p.m. Hospital Discharge Instructions for Resident #B indicated, "Status: Treatment, Medicine: bacitracin topical (bacitracin ointment) 1 App (application), How to take: to the skin once a day, Additional Instructions: Apply to left lateral foot stage 2 wounds...Comments: cover with mepilex border (foam dressing) for protection."</p> <p>The 5/28/15, 5:10 p.m. Admission</p>	F 0282	<p>I. All medical records were reviewed to ensure that all treatments were carried over and being implemented. II. All residents have the potential to be effected by the deficient practice. III. All nurses were re-educated to audit admissions/readmissions upon arrival to ensure proper physician's orders were in place. The ADON will immediately review all admissions/readmissions to ensure that all treatments are carried over to the MAR/TAR. IV. All admissions/readmissions will be audited during QAPI to ensure that admissions/readmissions were properly reviewed by the nurse and was free of errors. If errors are discovered to had been made during the admission/readmission process the ADON will be responsible for re-educating the nurse responsible</p>	06/23/2015

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	<p>Nursing Assessment indicated Resident #B had two stage 2 wounds to her left lateral foot/ankle area.</p> <p>An observation of Resident #B was made on 6/8/15 at 12:10 p.m. She was propelling herself in her wheel chair in the hallway. She was barefoot and had no bandage/dressing on her left foot.</p> <p>The May, 2015 and June, 2015 MARs (medication administration records) did not indicate bacitracin was applied to Resident #B's left lateral foot wounds on or after 5/31/15. They did not indicate the wounds were covered with mepilex border on or after her 5/28/15 return from the hospital.</p> <p>An interview was conducted with LPN #4 on 6/8/15 at 1:10 p.m. She reviewed Resident #B's 5/28/15 hospital discharge instructions for bacitracin and mepilex, as well as her June, 2015 MAR (medication administration record). LPN #4 indicated the order was not transcribed onto the MAR and she would get a clarification from the doctor. LPN #4 indicated Resident #B did not have a dressing on her left foot, nor had she seen her with one on her left foot since she'd returned from the hospital.</p> <p>An observation of Resident #B's left foot</p>			

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	<p>was made with LPN #4 on 6/8/15 at 1:40 p.m. Resident #B was still barefoot at this time with no dressing on her left foot. There were two, scabbed, dime sized wounds near the ankle.</p> <p>An interview was conducted with LPN #4 on 6/9/15 at 10:40 a.m. She indicated Resident #B's doctor said to go a head and do the bacitracin/mepilex treatment to Resident #B's two foot wounds.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 6/9/15 at 11:15 a.m. He indicated the mepilex should have been on Resident #B's foot since she came back from the hospital, and it probably would have helped the wounds heal more quickly. He indicated there was always a risk for infection if one is barefoot with open areas on the foot.</p> <p>This federal tag relates to Complaint #IN00174441.</p> <p>3.1-35(g)(2)</p>			