STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00108476. Complaint IN00108476 -- Unsubstantiated due to lack of sufficient evidence. Unrelated deficiencies are cited. Survey dates: May 22 and 23, 2012 Facility number: 000277 Provider number: 155611 AIM number: 100290530 Survey team: Penny Marlatt, RN Census bed type: SNF: 8 SNF/NF: 85 Total: 93 Census Payor type: Medicare: 4 Medicaid: 70 Other: 19 Total: 93 Sample: 3 Supplemental Sample: 3 These deficiencies reflect State findings	F0000	Please consider this plan of correction as Hoosier Christian Village's credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. Please accept this evidence in lieu of an onsite follow-up visit for the Investigation of Complaint IN00108476 on May 22 and 23, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2. Quality review completed on May 30, 2012 by Bev Faulkner, RN			

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F0176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.			
	Based on observation, interview and record review, the facility failed to ensure a resident was assessed to self- administer medications. Resident #C was observed to have his morning medication with him to take unsupervised. This deficient practice affected 1 of 3 sampled residents reviewed for respiratory issues and 1 of 17 residents observed during 2 medication pass observations with 4 facility staff. Findings include: Resident #C's clinical record was reviewed on 5-23-12 at 10:29 a.m. His diagnoses include, but are not limited to chronic ischemic heart disease, congestive heart failure, pacemaker, chronic obstructive pulmonary disease, depression and anxiety. His most recent Minimum Data Set assessment, dated 2-23-12, indicated he was cognitively intact. On 5-23-12 at 9:21 a.m., Resident #C was observed in his room with a large quantity, number unknown, of pills lying on his bed. He was observed to scoop the pills off of the bed and into his hand and	F0176	F176 It is the policy of Hoosier Christian Village when a resident wishes to self administer drugs, the interdisciplinary team will determine if the resident is safe to self administer drugs. The interdisciplinary team is responsible for ensuring the resident is capable and all required documentation is completed. · On 5/23/2012 one on one reeducation was given to QMA #1 that included the policy entitled “Oral Medications” requirement of remaining with the resident until he/she has taken all of his/her medication. QMA #1 verbalized understanding of the policy. On 6/01/2012 all residents who prefer to self administer their nebulizer treatments were identified and assessed per policy for self administration of medications. A doctor’s order was received and the plan of care was updated on each resident that was evaluated and found safe to self administer their nebulizer treatment. These identified residents will continue to be reviewed with any change in condition and quarterly by the interdisciplinary team to ensure safety as per policy. · All residents have the potential to be	06/08/2012

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	swallowed them. He then was observed to drink a clear fluid in an 8 ounce clear plastic cup. The resident then indicated, "I joke and say this is my breakfast cocktail, between my pills and the Miralax." Resident #C was queried as to if the nursing staff usually leave his pills for him or administer them to him. He indicated, "Some do and some don't." Resident #C was queried if he does his own breathing treatments. He indicated, "I do the treatment. The nurse fills up the medicine cup and I do it myself." On 5-23-12 at 12:20 p.m., in an interview with QMA #1, she indicated she had given Resident #C his medications earlier the same day. She indicated, "I don't usually leave his meds in his room, but it was real busy and [call] lights were going off, so I left them. He usually does his breathing treatments. The nurse puts the meds in for him and he does it when he is ready for it. I don't know off the top of my head if he is assessed to do his own meds, I'd have to look it up." In review of Resident #C's electronic Medication Administration Record (EMAR) for the medications administered on the morning of 5-23-12 and signed off by QMA #1, it indicated he received the following medications: Amiodarone 200 milligrams (mg); aspirin 81 mg; Colace		affected by this practice. During the weeks of May 28, 2012 and June 04, 2012, the Director of Nursing and Day and Evening Shift Nurse Supervisors completed room checks during and after med pass times to ensure that medications were not left unsupervised. No other residents were found to be affected by this practice. All supervisors will continue to monitor assigned rooms for unsupervised medications daily for 2 weeks and report any findings to the CQI team for further review and recommendations. Audits will continue prn with CQI recommendations. · During the week of June 4, 2012, nurses and QMAs were reeducated on the policy entitled “Oral Medications”. During the week of June 4, 2012 med pass audits were completed by the D.O.N., Day Shift, and Evening Shift Nurses Supervisors to ensure compliance with the “Oral Medications” policy that included remaining with the resident until he/she has taken all of her/his medication. These audits will continue weekly for one month to ensure compliance. Any findings will be brought to the CQI committee for review and any recommendations. Audits will continue prn with CQI recommendations. · Supervisors will continue monitoring on rounds for unsupervised medications as	

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	100 mg; Finasteride 5 mg; fluoxetine 10 mg; Miralax 17 grams; omeprazole 20 mg; prednisone 5 mg; Senna S 8.6/50 mg 2 tablets; Singulair 10 mg; carvedilol 25 mg; furosemide 40 mg; Klor Con 10 milliequivilents and lorazepam 1/2 of a 0.5 mg tablet, for a total of 14 prescriptions and 15 tablets of medication. The EMAR indicated he had received one breathing treatment of DuoNeb at 8:00 a.m., the same date and signed off by a licensed nurse. In interview with the Director of Nursing (DON) on 5-23-12 at 2:10 p.m., she indicated she could not locate a medication self administration assessment for Resident #C. A policy entitled, "Oral Medications," with a revision date of 12-7-11 was provided by the Administrator in Training on 5-23-12 at 2:10 p.m. This policy indicated, "Remain with the resident until he/she has taken all of his/her medications." A policy entitled, "Self-Administration of Medications," with a revision date of 12-7-11 was provided by the DON on 5-23-12 at 10:35 a.m. This policy indicated, "It is the policy of [name of the corporation] that the interdisciplinary team will ask the resident during the		directed by the CQI committee, with any finding brought to the CQI team for review and any further recommendations. · Completion Date: June 8, 2012	

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	assessment process whether he/she wishes to self-administer drugs. The interdisciplinary team is responsible for ensuring the resident is capable and all required documentation is completed." 3.1-11(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview and record review, the facility failed to ensure nursing staff verified the correct dosage of a narcotic medication prior to administration in accordance with physician orders and facility policy for 1 of 17 residents observed during 2 medication pass observations with 4 facility staff. This incorrect dosage was documented to have been administered 3 times previously. (Resident #D) Findings include: During a medication pass observation on 5-23-12 at 12:52 p.m. with QMA #1, she was observed to begin to prepare a prn (as needed) pain medication for Resident #D. The medication label indicated the medication to be Norco (combination product of hydrocodone and acetaminophen) 10/325 milligrams (mg) with the instructions indicated as the resident may receive one tablet by mouth every four hours for pain. During this preparation, she indicated the electronic Medication Administration Record (EMAR) indicated the physician order	F0282	F282 and F425 It is the policy of Hoosier Christian Village to provide services by qualified persons in accordance with each resident's written plan of care. Hoosier Christian Village policy does ensure availability of prescribed dosage of medications for administration. · On 5/23/12 a clarification order was received from resident D's medical doctor for Norco 10/325 mg to be administered by mouth every four hours as needed for pain and to discontinue the Norco 5/325mg order. Norco 10/325mg was obtained from the pharmacy per doctor's order. · All residents have the potential to be affected by this alleged deficiency. During the week of June 4, 2012 nurses and QMAs were reeducated on the policy "Oral Medications" that included verifying the physician's medication order for the resident's name, drug name, dose, time and route of administration, selecting the correct drug from the unit dose drawer and comparing the mediation label with the medication administration record. · Also, during the week of June 4, 2012 audits were completed during med passes by the D.O.N.,	06/08/2012

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	indicated the resident could receive two Norco 5/325 mg tablets by mouth every four hours as needed for pain. She then requested LPN #1 come to clarify the current physician order for the Norco prior to administration. Resident D's clinical record included a physician's order for Norco 5/325 mg, two tablets every four hours as needed for pain. In review of the "Controlled Substance Record" for Resident #D's Norco 10/325 mg, it indicated 30 tablets had been received by the facility on 5-21-12. The medication was identified as received by the facility with no signature, but by a staff using two initials with no time of receipt indicated. The record indicated the order for administration of this medication as, "Hydrodonone [sic]-APAP 10-325MG give 1 tablet orally every 4 hours as needed for pain." The record indicated 4 tablets had been dispensed since the medication was received on 5-21-12. In reviewing of the record with QMA #1 on 5-23-12 at 12:55 p.m., she indicated, "It looks like a medication error form will need to be filled out." Review of Resident D's clinical record indicated LPN #1 had obtained an order from the physician at 2:21 p.m., on		Day Shift and Evening Shift Nurse Supervisors that included comparing the medication label with the medication administration record. No other residents were found to be affected by this practice. · These audits will be completed weekly for one month and then prn as directed by the CQI committee by the supervisors to ensure compliance. Any finding from the audits will be brought to the CQI committee for review and any further recommendations. · Completion Date: June 08 , 2012.	

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	5/23/12 (the same date) to discontinue the Norco 5/325 mg order and had another new order for Norco 10/325 mg to be administered one tablet by mouth every four hours as needed for pain. In interview with the Director of Nursing (DON) on 5-23-12 at 5:12 p.m., she indicated with her review of the resident's clinical record, there was not an order for Norco 10/325 mg until this afternoon when the new order was received. She indicated the only Norco order she could find prior to the order changes this afternoon was for the two Norco 5/325 mg tablets every four hours as needed. A policy entitled, "Oral Medications," with a revision date of 12-7-11 was provided by the Administrator in Training on 5-23-12 at 2:10 p.m. This policy indicated, "Verify the physician's medication order for the resident's name, drug name, dose, time and route of administration. Select the correct drug from the stock supply or unit dose drawer. Compare the medication label with the medication administration record..." 3.1-35(g)(1) 3.1-35(g)(2)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. 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. 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. Based on observation, interview and record review, the facility failed to ensure the prescribed dosage of a narcotic was available for administration for 1 of 17 residents observed during 2 medication pass observations with 4 facility staff. This incorrect dosage was documented to have been administered 3 times previously. (Resident #D) Findings include: During a medication pass observation on 5-23-12 at 12:52 p.m., with QMA #1, she was observed to begin to prepare a prn (as	F0425	F282 and F425 It is the policy of Hoosier Christian Village to provide services by qualified persons in accordance with each resident's written plan of care. Hoosier Christian Village policy does ensure availability of prescribed dosage of medications for administration. · On 5/23/12 a clarification order was received from resident D's medical doctor for Norco 10/325 mg to be administered by mouth every four hours as needed for pain and to discontinue the Norco 5/325mg order. Norco 10/325mg was obtained from the pharmacy per doctor's order. · All residents have the potential to be affected	06/08/2012

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	needed) pain medication for Resident #D. The medication label indicated the medication to be Norco (combination product of hydrocodone and acetaminophen) 10/325 milligrams (mg) with the instructions indicated as the resident may receive one tablet by mouth every four hours for pain. During this preparation, she indicated the electronic Medication Administration Record (EMAR) indicated the physician order indicated the resident could receive two Norco 5/325 mg tablets by mouth every four hours as needed for pain. She then requested LPN #1 come to clarify the current physician order for the Norco prior to administration. Resident D's clinical record indicated the physician's order for Norco 5/325 mg, two tablets every four hours as needed for pain. The clinical record indicated LPN #1 had obtained an order from the physician at 2:21 p.m., the same date to discontinue the Norco 5/325 mg order and had another new order for Norco 10/325 mg to be administered one tablet by mouth every four hours as needed for pain. In review of the "Controlled Substance Record" for Resident #D's Norco 10/325 mg, it indicated 30 tablets had been received by the facility on 5-21-12. The		by this alleged deficiency. During the week of June 4, 2012 nurses and QMAs were reeducated on the policy “Oral Medications” that included verifying the physician’s medication order for the resident’s name, drug name, dose, time and route of administration, selecting the correct drug from the unit dose drawer and comparing the mediation label with the medication administration record. · Also, during the week of June 4, 2012 audits were completed during med passes by the D.O.N., Day Shift and Evening Shift Nurse Supervisors that included comparing the medication label with the medication administration record. No other residents were found to be affected by this practice. · These audits will be completed weekly for one month and then prn as directed by the CQI committee by the supervisors to ensure compliance. Any finding from the audits will be brought to the CQI committee for review and any further recommendations. · Completion Date: June 08 , 2012.	

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	medication was identified as received by the facility with no signature, but by a staff using two initials with no time of receipt indicated. The record indicated the order for administration of this medication as, "Hydrodonone [sic]-APAP 10-325MG give 1 tablet orally every 4 hours as needed for pain." The record indicated 4 tablets had been dispensed since the medication was received on 5-21-12. The record indicated Resident #D received Norco 10/325 mg as follows: one tablet on 5-21-12 at 7:00 p.m., two tablets on 5-22-12 at 7:45 a.m., and one tablet on 5-22-12 at 8:10 p.m. In reviewing of the "Controlled Substance Record" with QMA #1 on 5-23-12 at 12:55 p.m., she indicated, "It looks like a medication error form will need to be filled out." In interview with the Director of Nursing (DON) on 5-23-12 at 5:12 p.m., she indicated with her review of the resident's clinical record, there was not an order for Norco 10/325 mg until the afternoon of 5-23-12 when the new order was received. She indicated the only Norco order she could find prior to the order changes this afternoon was for the two Norco 5/325 mg tablets every four hours as needed.			

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	A policy entitled, "Oral Medications," with a revision date of 12-7-11 was provided by the Administrator in Training on 5-23-12 at 2:10 p.m. This policy indicated, "Verify the physician's medication order for the resident's name, drug name, dose, time and route of administration. Select the correct drug from the stock supply or unit dose drawer. Compare the medication label with the medication administration record... For narcotics, check the narcotic record for the previous drug count and compare it with the supply available. Report discrepancies to the staff/charge nurse." 3.1-25(b)			

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F0441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure	F0441	F441 It is the policy of Hoosier Christian Village to ensure proper	06/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/23/2012
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	proper hand hygiene as indicated by a facility staff member opening 5 capsules of medications with her bare, ungloved hands for 2 of 17 residents during 1 of 2 medication pass observations with 4 facility staff. (Residents #E and #F) Findings include: On 5-23-12 at 12:19 p.m., QMA #1 was observed to prepare medications for Resident #E. She was observed to open a capsule she identified as "potassium" with her bare, ungloved hands, into applesauce, in preparation for administration. She indicated this particular resident "can't swallow the big capsule, so this is what we do to help him." Resident #E's clinical record indicated he was physician-ordered to receive potassium chloride 10 milliequivilents three times daily by mouth. On 5-23-12 at 12:46 p.m., QMA #1 was observed to prepare medications for Resident #F. She was observed to open 4 capsules she identified as "Depakote" with her bare, ungloved hands, into applesauce in preparation for administration. She indicated this particular resident, "always takes his meds in applesauce."		hand hygiene as indicated to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. · On 5/23/12, one on one reeducation was given to QMA #1 on the policy "Oral Medication" that included not touching medication with hands. QMA #1 verbalized understanding on wearing gloves when opening capsules to empty contents. · All residents have the potential to be affected by this alleged deficiency. During the week of 6/04/12, nurses and QMAs were reeducated on the policy "Oral Medications" with ensuring that medications are not touched by bare hands. · During the week of 6/04/2012 audits were completed daily by the D.O.N., Day Shift and Evening Shift Nurse supervisors to ensure compliance with not touching medications with bare hands. · These audits will be completed weekly for one month and then prn as directed by the CQI committee with any finding brought to the CQI committee for review and any further recommendations. · Completion Date: June 8, 2012.	

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	Resident #F's clinical record indicated he was physician-ordered to receive Depakote Sprinkle capsule, four 125 milligrams each, for a total of 500 milligrams, three times daily by mouth. In interview with QMA #1 on 5-23-12 at 1:12 p.m., in regards to opening of the capsules with bare, ungloved hands, she indicated she had not thought about that. In interview with the Director of Nursing on 5-23-12 at 2:10 p.m., she indicated, "I would expect the nurse or QMA to wear gloves to open a capsule. Definitely shouldn't do that with bare hands. I believe that's what our policy says [to do.]" A policy entitled, "Oral Medications," with a revision date of 12-7-11 was provided by the Administrator in Training on 5-23-12 at 2:10 p.m. This policy indicated, "Do not touch the medicine with your hands." 3.1-18(b)			