STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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 a Recertification and State Licensure Survey. Survey dates: January 23, 24, 25, and 26, 2012 Facility number: 000361 Provider number: 155448 AIM number: 100266340 Survey team: Sheila Sizemore, RN, TC Marcia Mital, RN Regina Sanders, RN (January 25 and 26, 2012) Kelly Sizemore, RN Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 14 Medicaid: 50 Other: 14 Total: 78 Sample: 16 Supplemental Sample: 4 These deficiencies also reflect State findings cited in accordance with 410 IAC	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 2/25/12.**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	16.2. Quality review completed 1/27/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable interior related to stains on the walls, loose baseboard, dust and dirt on the floor, tears on a vinyl cover on a table and chair, broken electrical outlet cover, missing trim on a windows sill, and rusty table legs. This had the potential to affect 20 residents who eat their meals in the third floor dining room. (third floor dining room) Findings include: During the environmental tour on 01/25/12 from 9:45 a.m. to 10:35 a.m. with the Administrator and the Maintenance Supervisor the following was observed in the third floor dining room: There were white and brown substances splattered on two of the four walls. At the time of the observation, the Administrator indicated it looked like something had dripped on the wall. There was a loose baseboard and an accumulation of dust and dirt around the	F0253	**F253 – Housekeeping & Maintenance Services** It is the practice of this provider to ensure housekeeping and maintenance services are provided to maintain a sanitary and comfortable interior. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The walls of the third floor dining room have been cleaned and painted. The baseboard has been reattached to the wall. The dust, dirt and brown substance have all been cleaned off of the floor and baseboards. The horseshoe table has been removed and replaced. The cracked electrical outlet has been removed and replaced. The window trim has been removed and painted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All resident dining rooms have been thoroughly cleaned and checked to ensure a sanitary, orderly, and comfortable interior. Any issues were corrected at the time noted. ***What measures will be put into place or what or what systemic changes will be made to***	02/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	baseboards. The horseshoe table had tears on the vinyl covering and the legs of the table were rusted. There was missing trim around the window. There was plastic broken off the electrical outlet cover under the window. The vinyl on a rolling chair was cracked and torn. There was a dried puddle of a brown colored substance under the heating/cooling unit. During interview at the time of the observation, the Maintenance Supervisor indicated someone had probably spilled something. 3.1-19(e)		***ensure that the deficient practice does not recur:*** A mandatory in-service for all staff is scheduled for 2/14/12. This in-service will include review of the facility policy related to daily cleaning of dining rooms and other common areas. This in-service will also include how to report equipment that needs repair and will review the preventive maintenance guidelines for equipment and furniture repair to ensure a sanitary, orderly and comfortable interior. This in-service will be conducted by the SDC/designee. In addition, the ED and/or designee will make daily rounds using the "dining room environmental checklist" to observe all dining rooms for any housekeeping and/or maintenance issues. ***How the corrective action will be monitored to ensure the deficient practice will not recur ie., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the ED/designee will be responsible for completion of the CQI Audit Tool related to environmental rounds daily x 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
			changes will be completed: Compliance Date = 2/25/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure a resident admitted to the facility with an indwelling catheter was assessed to determine the clinical condition to justify the continued use of the catheter and failure to monitor and failed to record strict intake and output as ordered by the physician to assess a resident with the diagnosis of chronic renal failure for 2 of 4 residents reviewed for indwelling urinary catheters in a resident sample of 16. (Residents #31 and #38) Findings include: 1. During the initial tour on 1/23/12 at 10:15 a.m. with LPN #1, Resident #38 was observed sitting up in her reclining geri chair. The resident was observed to have a urinary catheter. During an interview at that time LPN #1 indicated the resident was admitted to the facility with the urinary catheter.	F0315	**F315 – No Catheter, Prevent UTI, Restore Bladder** It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #38 – indwelling catheter was discontinued on 1/24/12. A Three Day Void Assessment was completed followed by a new Bladder Assessment. The resident's care plan was reviewed and updated to reflect her current status. This resident experienced no negative outcome as a result of this finding.*	02/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	Resident #38's record was reviewed on 1/24/12 at 2:50 p.m. Resident #38's diagnoses included, but were not limited to, stroke, vascular dementia, and right sided weakness. Resident #38 was admitted to the facility on 11/4/11. An urinary catheter evaluation, dated 11/7/11, indicated the resident had a urinary catheter upon admission and the resident was unable to participate in a retraining program due to decreased cognitive and physical function. A catheter assessment dated, 11/7/11, indicated the diagnosis for the urinary catheter use was neurogenic bladder. An interview on 1/24/12 at 3:55 p.m., the ADoN (Assistant Director of Nursing) indicated she did not know why Resident #38 had an urinary catheter. She indicated she was going to call the doctor and have the urinary catheter removed. A physician's telephone order, dated 1/24/12 and received by the DNS (Director of Nursing Services) indicated "1/24/12, remove Foley catheter tomorrow 1/25/12 if no void in 6 hr (hours) check for residual...."		*Resident #31 – indwelling catheter was discontinued on 2/1/12. A Three Day Void Assessment was completed followed by a new Bladder Assessment. The resident's care plan was reviewed and updated to reflect her current status. This resident experienced no negative outcome as a result of this finding.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents with orders for use of an indwelling catheter and orders to monitor I&O have the potential to be affected by this finding. A facility audit will be conducted to identify all residents using indwelling catheters and being monitored for I&O. Each resident's clinical record will be reviewed to ensure there is appropriate clinical justification for ongoing use of the indwelling catheter and that this clinical justification is noted on each resident's plan of care. Each resident's clinical record will be reviewed to ensure the I&O documentation is complete. Any noted concerns will be corrected at that time. The Nurse Management Team is responsible for completion of this audit. ***What measures will be put into place or what systemic changes will be made to***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
			ensure that the deficient practice does not recur: A mandatory nursing in-service is scheduled for 2/14/12. This in-service will include review of the facility policy titled, "Bladder Program". This in-service will also review the specific guidelines and facility practices for residents using indwelling catheters. This in-service will also include re-education on complete and thorough documentation for I&O monitoring. Nursing staff will be re-educated regarding clinical justification for residents requiring use of indwelling catheters. The DNS/SDC/designee will be responsible for conducting this in-service. In addition, the DNS/IDT/designee will be responsible for determining ongoing need and justification for continued catheter use with appropriate supportive documentation with any new admission/re-admission and in conjunction with the MDS Assessment schedule along with complete and thorough documentation for I&O monitoring. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Urinary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	2. Resident #31's record was reviewed on 1/25/12 at 11:55 a.m. Resident #31's diagnoses included, but were not limited to, chronic renal failure, dementia, and stroke. A physician's order, dated 7/2/10, indicated "...Indication for use Foley catheter strict I & O (intake and output) secondary chronic renal insufficiency)..." A urinary & bowel continence evaluation form, dated 11/10/11, indicated the resident had a history of incontinence. The form indicated "Foley since renal failure per Husband..." A catheter assessment, dated 11/10/11, indicated "...Rational for use of catheter Renal Failure. Strict I & O. Diagnosis for catheter use Renal Failure. Has resident been evaluated by a Urologist in the past year or prior to catheter insertion? no		Continence/Catheter Use" along with a monitoring form titled "I&O tracking form" weekly x 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date = 2/25/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	(indicated by a check mark)..." The resident's Intake and Output forms dated 11/23/11 through 11/29/11, indicated a lack of monitoring of an output for 11/28/11 on the 3-11 shift and total output for the day. The weekly intake and output evaluation section of the form lacked documentation of monitoring of the average 24 hour output. The resident's Intake and Output forms dated 1/11/12 through 1/17/12, indicated a lack of monitoring of an output for 1/13/11 and 1/14/11 on the 7-3 shift and of total outputs for the days. The weekly intake and output evaluation section of the form lacked documentation of monitoring the average 24 hour output. During an interview on 1/25/11 at 12:15 p.m., the ADoN indicated the physician was monitoring the resident's laboratory test for the renal function. She indicated the physician was not looking at the I & O's. She indicated she was unable to find a diagnosis for the catheter. 3.1-41(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
F0504 SS=D	The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure laboratory tests were completed only as ordered by the physician for 2 of 16 residents' reviewed for laboratory services in a total sample of 16. (Resident #31 and #72) Findings include: 1. Resident #72's record was reviewed on 1/23/12 at 12:10 p.m. Resident #72's diagnoses included, but were not limited to, hypertension, stroke, and depression. At the bottom of a PT(pro-time) and INR (international normalized ratio) (blood clotting test for coumadin use) laboratory report, dated 12/28/11, indicated an order to continue same dose and check INR every 2 weeks and was signed by the physician on 12/29/11. The physician order recapitulation for January 2012, indicated the PT/INR was to be done weekly instead of the physician ordered every two weeks. The resident's record indicated PT/INR levels were drawn on 1/4/12, 1/11/12, and 1/18/12.	F0504	**F504 – Lab Services Only When Ordered by Physician** It is the practice of this provider to obtain laboratory services only when ordered by the attending physician. ***What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice:*** *Resident #72 – laboratory orders have been clarified with the physician. The February Physician Order Sheet accurately reflects this correction. This resident experienced no negative outcome as a result of this finding.* *Resident #31 – laboratory orders have been clarified with the physician. The February Physician Order Sheet accurately reflects this correction. This resident experienced no negative outcome as a result of this finding.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents with laboratory orders have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will review all residents with laboratory orders to ensure all	02/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	During an interview with the ADoN (Assistant Director of Nursing), on 1/24/12 at 11:21 a.m., she indicated an order was not written to do the PT/INR every 2 weeks and they continued to do it every week.		labs are obtained only as ordered. Any identified discrepancies will be corrected and/or clarified when noted. Physician Orders are reviewed daily by the DNS/designee. All physician orders related to labs will be cross referenced to the Lab Requisition Form to ensure labs are obtained as ordered. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A mandatory nursing in-service is scheduled for 2/14/12. This in-service will include review of the facility policy titled, "Guidelines for Lab Tracking". The in-service will emphasize the importance of following physician orders regarding lab monitoring and obtaining labs per physician's order. The DNS/SDC/designee will be responsible for conducting this in-service. Physician Orders are reviewed daily by the DNS/designee. All physician orders related to labs will be cross referenced to the Lab Requisition Form daily to ensure labs are obtained as ordered. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie., what quality assurance program will be put into place:*** Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
	2. Resident #31's record was reviewed on 1/25/12 at 11:55 a.m. Resident #31's diagnoses included, but were not limited to, chronic renal failure, dementia, and stroke. A physician's order, dated 10/7/11, indicated "discontinue valproic acid level monthly. lab draw Q (every) 6 months for valporic acid level." The resident's record indicated a laboratory test results for valporic acid dated 12/5/11 and 1/16/12. During an interview on 1/25/11 at 12:15 p.m., the ADoN indicated the valporic acid level should not have been drawn until April 2012. 3.1-49(f)(1)		responsible for completion of the CQI Audit Tool titled, “Laboratory Services” weekly x3 weeks, then monthly x 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date = 2/25/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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