STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155448	A. BUILDING B. WING		01/26/2012
LOWEL	PROVIDER OR SUPPLIER		710 MIO	ADDRESS, CITY, STATE, ZIP CODE CHIGAN ST .L, IN 46356	
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	State Licensure Survey dates: Ja 2012 Facility number: Provider number AIM number: Survey team: Sheila Sizemore Marcia Mital, RI Regina Sanders, 2012) Kelly Sizemore, Census bed type SNF/NF: 78 Total: 78 Census payor type Medicare: 14 Medicaid: 50 Other: 14 Total: 78 Sample: 16 Supplemental Sa These deficienci	000361 r: 155448 100266340 , RN, TC N RN (January 25 and 26, RN :	F0000	The creation and submission of this plan of correction does not constitute an admission this provider of any conclusi set forth in the statement of deficiencies, or of any violati of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and reques a desk review certification of compliance on or after 2/25/1	es by on on e

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDEN	ROVIDER/SUPPLIER/CLIA TIFICATION NUMBER: 5448	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 01/26	LETED
	PROVIDER OR SUPPLIER HEALTHCARE		710 MIC	ADDRESS, CITY, STATE, ZIP COD CHIGAN ST .L, IN 46356	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PERCEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
		DENTIFYING INFORMATION) letted 1/27/12		CROSS-REFERENCED TO THE APPL DEFICIENCY)	ROPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 2 of 14

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	N IDENTIFICATION NUMBER: A. BUILDING		DING	00 COMP		ETED
		155448	B. WIN			01/26/	2012
			B. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CHIGAN ST		
LOWELL	LIEALTHOADE						
LOVVELL	HEALTHCARE			LOVVEL	_L, IN 46356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253	The facility must p	rovide housekeeping and					
SS=E		ices necessary to maintain					
ļ	a sanitary, orderly	, and comfortable interior.	Į.		ļ	ļ	, l
			F02	53	F253 – Housekeeping &		02/25/2012
	Based on observa	ation and interview, the			Maintenance Services		
		ensure housekeeping and			It is the practice of this provide	r to	
	-	vices were provided to			ensure housekeeping and		
		-			maintenance services are	,	
		ry and comfortable			provided to maintain a sanitary and comfortable interior.	′	
		stains on the walls,			What corrective action(s) will	,	
	loose baseboard,	dust and dirt on the			be accomplished for those	,	
	floor, tears on a	vinyl cover on a table and			residents found to have been	,	
	chair, broken ele	ctrical outlet cover,			affected by the deficient	•	
	•	a windows sill, and rusty			practice:		
	_				The walls of the third floor dini	ng	
	•	and the potential to affect			room have been cleaned and		
		eat their meals in the			painted. The baseboard has		
	third floor dining	g room. (third floor			been reattached to the wall. T		
	dining room)				dust, dirt and brown substance		
					have all been cleaned off of th	е	
	Findings include				floor and baseboards. The		
	i mamgs merade	•			horseshoe table has been		
	D : 41 :	. 1 .			removed and replaced. The cracked electrical outlet has be	oon	
	During the envir				removed and replaced. The	ECII	
		45 a.m. to 10:35 a.m.			window trim has been remove	d	
	with the Adminis	strator and the			and painted.	-	
	Maintenance Sur	pervisor the following			How other residents having t	he	
	was observed in	the third floor dining			potential to be affected by th		
	room:	5			same deficient practice will k		
	100111.				identified and what correctiv	е	
	There were white	e and brown substances			action(s) will be taken:		
					All resident dining rooms have		
	•	of the four walls. At the			been thoroughly cleaned and		
		vation, the Administrator			checked to ensure a sanitary,		
	indicated it looke	ed like something had			orderly, and comfortable interior		
	dripped on the w	all.			Any issues were corrected at t time noted.	i i C	
					What measures will be put in	to	
	There was a loos	e baseboard and an			place or what or what systen		
		dust and dirt around the			changes will be made to		
	accumulation of	ausi ana ant arbuna me	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 3 of 14

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	4 DI III	LDDIC	00	COMPL	ETED
		155448		LDING		01/26/	2012
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					CHIGAN ST		
LOWELL	. HEALTHCARE			LOWEL	L, IN 46356		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
1110				1110	ensure that the deficient		Dille
	baseboards.				practice does not recur:		
					A mandatory in-service for all		
	The horseshoe t	able had tears on the vinyl			staff is scheduled for 2/14/12.		
	covering and the	e legs of the table were			This in-service will include revi	iωw	
	rusted.	o regio er une unere were			of the facility policy related to	-	
	Tusteu.				cleaning of dining rooms and	adily	
					other common areas. This		
	There was missi	ing trim around the			in-service will also include how	/ to	
	window.				report equipment that needs	0	
					repair and will review the		
	Thora was mlost	is broken off the electrical			preventive maintenance		
	_	ic broken off the electrical			guidelines for equipment and		
	outlet cover und	ler the window.			furniture repair to ensure a		
					sanitary, orderly and comfortal	ble	
	The vinvl on a r	olling chair was cracked			interior. This in-service will be		
	and torn.				conducted by the SDC/design	ee.	
	and tom.				In addition, the ED and/or		
					designee will make daily round	ds	
	There was a drie	ed puddle of a brown			using the "dining room		
	colored substance	ce under the			environmental checklist" to		
	heating/cooling	unit. During interview at			observe all dining rooms for ar	ny	
	the time of the o	_			housekeeping and/or		
		· ·			maintenance issues.		
		pervisor indicated			How the corrective action wi	II	
	someone had pr	obably spilled something.			be monitored to ensure the		
					deficient practice will not red	ur	
	3.1-19(e)				ie., what quality assurance		
	3.1 15(0)				program will be put into plac		
					To ensure ongoing compliance	Э	
					with this corrective action, the		
					ED/designee will be responsib		
					for completion of the CQI Audi	t	
					Tool related to environmental		
					rounds daily x 3 weeks and		
					monthly for 6 months. If	_	
					threshold of 90% is not met, a	П	
					action plan will be developed.		
					Findings will be submitted to the CQI Committee for review and		
						1	
					follow up.		
					By what date the systemic		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet Page 4 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CO A. BUILDING B. WING	00		
LOWELL	PROVIDER OR SUPPLIE	R	710 MI	ADDRESS, CITY, STATE, ZIP CHIGAN ST LL, IN 46356	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE DEFICIENCY)		(X5) COMPLETION DATE
				changes will be com Compliance Date = 2/		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 5 of 14

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155448	B. WIN			01/26/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CHIGAN ST		
LOWELL	HEALTHCARE				L, IN 46356		
(X4) ID	STIMMARY	FATEMENT OF DEFICIENCIES	1	ID	T		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0315		dent's comprehensive					
SS=D		acility must ensure that a					
		rs the facility without an					
	indwelling cathete	r is not catheterized unless					
		cal condition demonstrates					
		n was necessary; and a					
		continent of bladder					
		ate treatment and services tract infections and to					
		ormal bladder function as					
	possible.						
	Based on observa	ation, record review and	F03	15	F315 – No Catheter, Prevent	•	02/25/2012
	interview, the fac	cility failed to ensure a			UTI, Restore Bladder		
	-	I to the facility with an			It is the practice of this provide		
		ter was assessed to			ensure that a resident who ent		
	_	nical condition to justify			the facility without an indwellin catheter is not catheterized	9	
		e of the catheter and			unless the resident's clinical		
		r and failed to record			condition demonstrates that		
					catheterization was necessary		
		output as ordered by the			and a resident who is inconting		
		ss a resident with the			of bladder receives appropriate treatment and services to prev		
	_	onic renal failure for 2 of			urinary tract infections and to	CIII	
		wed for indwelling			restore as much normal bladde	er	
		in a resident sample of			function as possible.		
	16. (Residents #	31 and #38)			What corrective action(s) will	I	
					be accomplished for those	_	
	Findings include	•			residents found to have beer affected by the deficient	1	
					practice:		
	1. During the init	tial tour on 1/23/12 at			Resident #38 – indwelling		
	•	LPN #1, Resident #38			catheter was discontinued on		
		ting up in her reclining			1/24/12. A Three Day Void		
		esident was observed to			Assessment was completed		
	_	theter. During an			followed by a new Bladder Assessment. The resident's c	are	
	_	time LPN #1 indicated			plan was reviewed and update		
		admitted to the facility			to reflect her current status. The		
		,			resident experienced no negat		
	with the urinary	cameter.			outcome as a result of this		
					finding.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet Page 6 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, pull paid	00	COMPLETED
		155448	A. BUILDING		01/26/2012
			B. WING		
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
				ICHIGAN ST	
LOWELL	HEALTHCARE		LOWE	ELL, IN 46356	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Resident #38's	record was reviewed on		Resident #31 – indwelling	
	1/24/12 at 2:50	p.m. Resident #38's		catheter was discontinued on	
		ded, but were not limited		2/1/12. A Three Day Void	
	"			Assessment was completed	
		ular dementia, and right		followed by a new Bladder	
		. Resident #38 was		Assessment. The resident's	
	admitted to the	facility on 11/4/11.		plan was reviewed and updat	
				to reflect her current status. Tresident experienced no nega	
	An urinary cath	eter evaluation, dated		outcome as a result of this	luve
		ted the resident had a		finding.	
		upon admission and the		How other residents having	the
	1 *	•		potential to be affected by the	
		able to participate in a		same deficient practice will	
		ram due to decreased		identified and what corrective	
	cognitive and p	hysical function.		action(s) will be taken:	
				All residents with orders for us	se of
	A catheter asses	ssment dated, 11/7/11,		an indwelling catheter and ord	
		agnosis for the urinary		to monitor I&O have the poter	
		s neurogenic bladder.		to be affected by this finding.	
	catheter use wa	s neurogenic biadder.		facility audit will be conducted	l to
				identify all residents using indwelling catheters and being	_
		n 1/24/12 at 3:55 p.m., the		monitored for I&O. Each	9
	ADoN (Assista	nt Director of Nursing)		resident's clinical record will b	ne
	indicated she di	d not know why Resident		reviewed to ensure there is	
	#38 had an urin	ary catheter. She		appropriate clinical justificatio	n for
		as going to call the doctor		ongoing use of the indwelling	
				catheter and that this clinical	
	and have the ur	inary catheter removed.		justification is noted on each	
				resident's plan of care. Each	
	A physician's te	elephone order, dated		resident's clinical record will b	oe e
	1/24/12 and rec	eived by the DNS		reviewed to ensure the I&O	
	(Director of Nu	rsing Services) indicated		documentation is complete. A	-
	`	ve Foley catheter		noted concerns will be correct at that time. The Nurse	ıeu
	•	12 if no void in 6 hr		Management Team is	
				responsible for completion of	this
	(hours) check for	or residual		audit.	
				What measures will be put in	nto
				place or what systemic	
				changes will be made to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet Page 7 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/26/2012
	PROVIDER OR SUPPLIE	R	710 MI	ADDRESS, CITY, STATE, ZIP CODE CHIGAN ST LL, IN 46356	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				ensure that the deficient practice does not recur: A mandatory nursing in-serv scheduled for 2/14/12. This in-service will include review the facility policy titled, "Blad Program". This in-service wi also review the specific guide and facility practices for residusing indwelling catheters. In-service will also include re-education on complete and thorough documentation for monitoring. Nursing staff will re-educated regarding clinical justification for residents requuse of indwelling catheters. DNS/SDC/designee will be responsible for conducting the in-service. In addition, the DNS/IDT/designee will be responsible for determining ongoing need and justification continued catheter use with appropriate supportive documentation with any new admission/re-admission and conjunction with the MDS Assessment schedule along complete and thorough documentation for I&O monitoring. How the corrective action(swill be monitored to ensure deficient practice will not reference in the monitored to ensured deficient practice will not reference on the completion of the CQI Auton to the completion of the CQI Auton titled, "Urinary"	of der all elines dents This d al

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 8 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/26/2012
	PROVIDER OR SUPPLIER HEALTHCARE	710 MI	ADDRESS, CITY, STATE, ZIP CODE CHIGAN ST LL, 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 APPROPRIA DEFICIENCY)	DATE
	2. Resident #31's record was reviewed on 1/25/12 at 11:55 a.m. Resident #31's		Continence/Catheter Use" alowith a monitoring form titled "I tracking form" weekly x 3 wee and monthly for 6 months. If threshold of 90% is not met, a 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.	&O ks n he
	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			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 9 of 14

	of Correction identification number: 155448	A. BUILDING B. WING	TION	COMPLETED 01/26/2012
	PROVIDER OR SUPPLIER HEALTHCARE			1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
	(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)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 10 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155448	B. WING		01/26/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				CHIGAN ST	
LOWELL	. HEALTHCARE		LOWEL	_L, IN 46356	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	}	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0504 SS=D		provide or obtain laboratory en ordered by the attending			
00 5	physician.	on a constant by the attending			
	Based on record	review and interview, the	F0504	F504 - Lab Services Only Wi	nen 02/25/2012
	facility failed to	ensure laboratory tests		Ordered by Physician	
	were completed	only as ordered by the		It is the practice of this provide obtain laboratory services only	
	physician for 2 of	of 16 residents' reviewed		when ordered by the attending	
		ervices in a total sample of		physician.	,
	16. (Resident #3	•		What corrective action(s) will	ı l
		,		be accomplished for those	
	Findings include	e:		residents found to have been affected by this deficient	1
				practice:	
	 1 Resident #72	s's record was reviewed on		Resident #72 – laboratory ord	ers
		p.m. Resident #72's		have been clarified with the	
		ded, but were not limited		physician. The February	
	_	, stroke, and depression.		Physician Order Sheet accurate reflects this correction. This	tely
	to, hypertension	, stroke, and depression.		resident experienced no nega	tive
	At the bottom of	f a PT(pro-time) and INR		outcome as a result of this	
		ormalized ratio) (blood		finding.	
	`	coumadin use) laboratory		Resident #31 – laboratory ord	ers
	_	/28/11, indicated an order		have been clarified with the physician. The February	
	1 * '	e dose and check INR		Physician Order Sheet accura	telv
		nd was signed by the		reflects this correction. This	
	physician on 12			resident experienced no nega	tive
		729/11.		outcome as a result of this	
	TPL11-1			finding. How other residents having	tho
		rder recapitulation for		potential to be affected by the	
	1	ndicated the PT/INR was		same deficient practice will l	
		tly instead of the physician		identified and what corrective	re
	ordered every tw	vo weeks.		action(s) will be taken:	
	mi ii ii	1: 1: 1 1 2 2 2 2 2		All residents with laboratory orders have the potential to be	,
		ecord indicated PT/INR		affected by this finding. A faci	
		vn on 1/4/12, 1/11/12, and		audit will be completed by the	
	1/18/12.			Nurse Management Team. The	
				audit will review all residents v	
				laboratory orders to ensure all	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 11 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CONSTRU A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/26/2012
LOWELL	PROVIDER OR SUPPLIER HEALTHCARE	STREET ADDRE 710 MICHIG LOWELL, IN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIA 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.	order disconding and physical	s are obtained only as ered. Any identified crepancies will be corrected for clarified when noted. It is claim orders are reviewed by the DNS/designee. A sician orders related to lab be cross referenced to the Requisition Form to ensure are obtained as ordered. It is are obtained as ordered. It is are obtained as ordered. It is ervice will be made to sure that the deficient of citied does not recur: It is ervice will include review of facility policy titled, it idelines for Lab Tracking". It is ervice will emphasize ortance of following physicilers regarding lab monitoring lobtaining labs per physiciler. The DNS/SDC/designeer. The DNS/SDC/designeer responsible for conduct in-service. Physician Order reviewed daily by the S/designee. All physician ers related to labs will be so referenced to the Lab quisition Form daily to ensure a sicient practice will not recompare to the corrective action(s) are obtained as ordered. It is the corrective action(s) are obtained as ordered of the corrective action will be monitored to ensure a sicient practice will not recompare will be put into place of the facility cQI programs of the facility c	dilliss re nto e is f the cian g an's e ting ers ure

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 12 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155448		A. BUILDING B. WING		COMPLETED 01/26/2012			
	PROVIDER OR SUPPLIER L HEALTHCARE	3	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	1/25/12 at 11:55 diagnoses include to, chronic renal stroke. A physician's ordindicated "discommonthly, lab dra valporic acid levent The resident's relaboratory test redated 12/5/11 and During an interview. The ADON	cord indicated a esults for valporic acid d 1/16/12. iew on 1/25/11 at 12:15 indicated the valporic d not have been drawn		responsible for completion of the CQI Audit Tool titled, "Laborate Services" weekly x3 weeks, the monthly x 6 months. If threshold of 90% is not met, an action play will be developed. Findings who be submitted to the CQI Committee for review and follows. By what date the systemic changes will be completed: Compliance Date = 2/25/12.	ory en bld lan ill		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet Page 13 of 14

PRINTED: 02/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155448		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/26/2012	
	PROVIDER OR SUPPLIE	R	710 MIC	ADDRESS, CITY, STATE, Z CHIGAN ST L, IN 46356	TIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	F CORRECTION ON SHOULD BE THE APPROPRIATE Y)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM9S11

Facility ID: 000361

If continuation sheet

Page 14 of 14