

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2012
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NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: April 24, 25, 26, 27, 30 and May 1, 2012</p> <p>Facility number: 000248 Provider number: 155357 AIM number: 100291470</p> <p>Survey team: Tammy Alley RN TC DeAnn Mankell RN Toni Maley BSW</p> <p>Census bed type: SNF/NF: 99 Residential: 49 Total: 148</p> <p>Census payor type: Medicare: 24 Medicaid: 50 Other: 74 Total: 148</p> <p>Residential Sample: 9</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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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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	Quality review completed 5/3/12 Cathy Emswiller RN				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident with a history of gross hematuria (blood in the urine) and on-going symptoms had a care plan to address this medical condition for 1 of 1 residents reviewed with a diagnoses of hematuria. (Resident #176)</p> <p>Findings include:</p> <p>Resident #176's closed record was reviewed on 4/26/12 at 10:00 p.m. Resident #176 was admitted to the</p>	F0279	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 14, 2012 <u>F 279 483.20 (d), 483.20 (k) DEVELOP</u></p>	05/14/2012	

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	<p>facility on 3/22/12. Resident #176's admission diagnoses included, but were not limited to, chronic kidney disease, a history of prostate cancer and a history of gross hematuria.</p> <p>Resident #176 had a 3/6/12 hospital history and physical which indicated "Gross hematuria. He was hospitalized ..in early January. He did receive 2 units of packed red cells. ...IMPRESSIONS: 1. Anemia/thrombocytopenia. We will transfuse with 2 units of packed red blood cells. ... 4. Hematuria. There is a questionable renal mass on a recent CT. He has known bladder tumor. We will ask urology to follow up."</p> <p>Resident #176's progress notes included, but were not limited to, the following documentation of blood in his urine:</p> <p>a.) 4/24/12, 3:52 A.M.-Resident admitted to hospital with diagnoses of hematuria, UTI (urinary tract infection) and urinary retention. The hospital was contacted @ 0250 a.m. [at 2:50 a.m.]</p> <p>b.) 4/24/12, 11:51 p.m.- The hospital was contacted regarding the resident's status. The resident had</p>		<p><u>COMPREHENSIVE CARE PLANS</u> I. Resident # 176 has been re admitted to the facility. He no longer has an indwelling foley catheter. II. All residents with indwelling foley catheters were reviewed on 4-30-2012 for presence of care plans. All residents with indwelling foley catheters have a care plan in place. III. The systemic change is that the facility will review residents with new foley catheter placement or new onset of hematuria for placement of a care plan during clinical stand up meeting. Education will be provided to all licensed staff regarding comprehensive care planning when residents have an indwelling foley catheter or new onset of hematuria. IV. The DON or designee will audit residents with new indwelling foley catheters or new onset of hematuria 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. See Audit Tool #2 regarding Foley Catheters COMPLETION DATE: May 14, 2012</p>		

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	<p>received continuous irrigation and had based multiple urinary blood clots and approximately 800 ml [milliliters] urine.</p> <p>c.) 4/23/12, 4:45 p.m.- Resident complained of increased groin pain and continued hematuria request to be sent to hospital.</p> <p>d.) 4/23/12-3:10 a.m.-no c/o [complaints of] bladder pain</p> <p>e.) 4/22/12-10:50 p.m.- Resident complained of pressure to penis. Foley Catheter irrigated. Resident tolerated well. Resident stated had relief.</p> <p>f.) 4/22/12, 6:41 p.m.- Foley cath patent, draining dark red urine, no c/o (complaints of) pain</p> <p>g.) 4/22/12, 12:51 p.m., "...hematuria noted in cath [catheter] bag..."</p> <p>h.) 4/21/12-2:17 a.m.- "...cath patent but continues to drain frank blood with urine..."</p> <p>i.) 4/20/12, 1:16 p.m.- "...cath patent draining dark red urine. denies burning"</p> <p>j.) 4/18/12, 10:21 p.m.-"urinary cath</p>			

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	<p>continues to drain bloody urine...."</p> <p>k.) 4/17/12-10:30 p.m., - "... Foley cath patent draining dark red urine...no c/o discomfort at this time."</p> <p>l.) 4/16/12-8:55 p.m.- "Foley cath continues to drain dark red urine...no c/o pain."</p> <p>m.) 4/13/12-10:05 a.m.-"Foley cath continues to drain dark red urine with sediment."</p> <p>n.) 4/13/12-3:33 a.m.- "res (resident) with moderate amount of blood in UD[urinary dignity] bag. No c/o pain or discomfort related to UTI [urinary tract infection]."</p> <p>o.) 4/12/12-7:32 p.m.-"draining dark red urine"</p> <p>p.) 4/12/12-10:48 a.m.-"draining dark red blood with sediment."</p> <p>q.) 4/11/12-10:38 a.m.-"draining bright red urine with sediment."</p> <p>r.) 4/10/12-9:44 a.m.-"resident presents with bright red drainage in cath bag with clots present. Notified MD. ... draw CBC [complete blood count] and see Urologist today at 1:50 p.m."</p>				

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	<p>Following the 4/10/12 urology consult, the clinical record lacked any record of communication with the urologist regarding a directed plan of care by the urologist or general practitioner.</p> <p>On 4/27/12 the facility obtained a progress note from the urologist which indicated:</p> <p>"4/10/12- his urine was clear until this morning...having gross hematuria and passing clots in his catheter. ...I did irrigate his bladder and obtained a few clots in return. I was able to get him clear with irrigation." The note did not indicate if urologist expected the resident to continue to have blood in his urine or to pass clots. The information contained in the progress note was not housed in the facility until 4/27/12.</p> <p>The clinical record indicated the resident saw a nephrologist on 4/16/12. The resident did receive lab orders from the nephrologist but no care instructions.</p> <p>Resident #176's clinical record, from admission to discharge, lacked a care plan to address gross hematuria.</p>						

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	<p>During a 4/27/12, 1:36 p.m., interview the Director of Nursing (DoN) indicated the facility was monitoring Resident 176's vital signs, urinary output, urine color, pain and the patency of the catheter. She indicated after 4/16/12 the resident had a weekly CBC (laboratory test which identifies blood loss and anemia). The DoN indicated these approaches were basic nursing practice.</p> <p>During a 4/27/12, 1:55 p.m., interview, The R.N. consultant indicated that although the facility was providing ongoing care and services for the resident, the facility had not developed a care plan to address hematuria.</p> <p>Review of a current, 12/07, facility policy titled, Catheter Care, Urinary, which was provided by DoN on 4/30/12 at 1:50 p.m., indicated the following:</p> <p>"Check the urine for unusual appearance (i.e., color, blood, etc.)" "Notify the supervisor immediately in the event of hemorrhage (bleeding), or if the catheter is pulled out."</p>			

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	3.1-35(a)			
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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, interview, and record review, the facility failed to</p>	F0441	Preparation and/or execution of this plan of correction in general,	05/14/2012	

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	<p>ensure infection control practices were followed related to the handling of a syringe (RN # 4) (Resident # 181) and handwashing/glove use during 1 of 2 personal care observations (CNA # 2 and CNA # 3) (Resident # 101, 127, and 95).</p> <p>Findings include:</p> <p>1. During a medication pass observation on 4/26/12 at 11:18 a.m., RN # 4 gave resident # 181 an insulin injection. She then recapped the syringe while in the resident room. She then exited the room with the capped syringe and at time during interview, she indicated she had recapped the syringe and should not have. She indicated the facility used to have the safety syringes for use.</p> <p>A policy titled "Sharps Disposal" was provided by the Director of Nursing on 4/30/12 at 1 p.m., and deemed as current. The policy indicated: "...6. No one shall bend, recap, or break used syringe needles before discarding into the sharps container...."</p> <p>2. During a care observation of Resident # 101, on 4/26/12 at 10 a.m.. CNA # 2 and # 3 entered the</p>		<p>or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 14, 2012 <u>F-441 483.65</u> <u>INFECTION CONTROL, PREVENT SPREAD, LINEN I.</u> Residents numbers 181,101 127 and 95 were reviewed and have had no signs or symptoms of infection requiring antibiotic use since survey completion. II. All licensed nursing staff will be offered education regarding handling and disposing of sharps. All nursing staff will be offered education regarding handwashing procedure. III. The systemic change includes that all newly hired nurses will receive education for appropriate infection control practice when handling and disposing of sharps. In addition, all newly hired nursing personnel will receive education on hand washing. All current nurses will be offered education for appropriate infection control practice when handling and disposing of sharps. In addition, all nursing personnel will receive education on hand washing. IV.</p>				

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	<p>resident's room. They first provided positioning for resident # 127 who was the roommate of Resident 101, then they went to Resident # 101 and began care. CNA # 2 applied the gait belt and both CNA's assisted Resident 101 to stand and transfer to her recliner. The gait belt was removed. CNA # 3 then left Resident # 101's room and entered Resident # 95's room who was asking for assistance. The CNA then pushed Resident # 95's wheelchair into the bathroom. No handwashing or sanitizing was observed between resident to resident care observations.</p> <p>A policy titled "Handwashing/Hand Hygiene" was provided by the Director of Nursing on 4/30/12 at 1 p.m., and deemed as current. The policy indicated: 5. Employees must wash their hands for at least fifteen (15) seconds, using antimicrobial or non-antimicrobial soap and water under the following conditions:...c. Before and after direct resident contact...."</p> <p>3.1-18(l)</p>		<p>Director of Nursing and or designee will audit through direct observations on infection control practices as related to handling and disposing of sharps and hand washing procedure 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. See Audit Tool #3 regarding handling and disposing of sharps. See Audit Tool #4 regarding handwashing. COMPLETION DATE: May 14, 2012</p>		

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R0239	<p>410 IAC 16.2-5-4(c) Health Services - Nonconformance (c) Each facility shall choose whether or not it administers medication or provides residential nursing care, or both. These policies shall be delineated in the facility policy manual and clearly stated in the admission agreement.</p> <p>Based on observation, record review, and interview, the facility failed to follow the Medication Administration Policy for the administration of an inhaled medication for 1 of 5 residents observed during the medication pass (Resident R-27).</p> <p>Findings included:</p> <p>1. During the medication pass on 4/30/12 at 10:45 A.M., Resident R-27 was observed receiving her inhaled "Proair HFA (albuterol sulfate)." LPN #1 had Resident R-27 take one puff of the inhaler. She counted 1-2-3 and gave the resident a second puff of the medication.</p> <p>During interview on 4/30/12 at 12:45 P.M., LPN #1 was queried regarding the amount of time that should lapse between the administration of the 2 puffs from the inhaler. She indicated "I don't know."</p> <p>Review of the clinical record for Resident R-27 on 5/1/12 at 10 a.m., the physician orders includes an order for "Proair HFA</p>	R0239	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 14, 2012 <u>R 239 410 IAC 16-2-5 (c) Health Services-Nonconformance</u> I. Resident R-27 receives her Proair HFA-2 puffs by mouth 4 x daily (before meals and at bedtime). Resident R- 27 has received her Proair HFA correctly with appropriate time between 2 puffs since survey completion. II. All licensed nursing staff will be offered education regarding administering medication inhalers and when more than one puff is ordered by the physician. III. The systemic change includes that all newly hired nurses will receive education for use of medication</p>	05/14/2012			

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NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064		
(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>"Inhale 2 puffs by mouth 4 x daily (before meals and at bedtime) (7:30 A.M., 11:30 A.M., 5 P.M., 9 P.M.)</p> <p>The medication insert which was removed from the medication box, was provided by LPN # 1 on 4/30/12 at 10:45 a.m., after the above medication administration, indicated ".... 5. If your doctor has prescribed more sprays, wait 1 minute and shake the inhaler again. Repeat steps 2 through 4...."</p> <p>Review of the "Medication Administration: General Policies & Procedure" provided by the Administrator on 4/30/12 at 1:35 P.M., indicated "Policy.... All medications are to be administered only as prescribed by a physician and only by licensed medical or nursing personnel.... Personnel administering drugs shall refer to the PDR (Physician's Desk Reference) or its equivalent when unfamiliar with the pharmacology of the drug, its potential toxic effects or contraindications...."</p>		<p>inhalers and appropriate time between puffs per physician's order. All current nurses will be offered education for use of medication inhalers and appropriate time between puffs per physician's order. IV. Director of Nursing and or designee will audit through direct observations on use of medication inhalers and appropriate time between puffs per physician's order 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. See Audit Tool #1 regarding Inhaler</p> <p>COMPLETION DATE: May 14, 2012</p>		