

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint #IN00121630.</p> <p>Complaint #IN0121630 unsubstantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 14-18, 22-23, 2013</p> <p>Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 13 Medicaid: 57 Other: 24 Total: 94</p>	F0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>These deficiencies reflect findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 01/25/2013 by Brenda Nunan, RN.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy for personal care for 3 of 4 residents who met the criteria for privacy and 1 of 4 random observations of personal care and/or insulin injections and gastrostomy tube medication administration</p>	F0164	<p>This Plan of Correction constitutes Exceptional Living Center of Brazil written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was sited correctly. This plan is submitted to meet requirements established by state</p>	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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>[Residents #108, #95, #44, and #13].</p> <p>Findings include:</p> <p>1. On 1/22/13 at 9:45 a.m., Resident #108 was observed receiving a shower in the back hall shower room. CNA #1 was providing the shower. The resident was in the second shower stall. The clear, plastic shower curtain was pulled one half way across the stall. CNA #1 was positioned in front of resident. The CNA indicated the resident does not like the curtain pulled all of the way across the stall. During the shower, CNA #2 entered the shower room without knocking, walked across the shower room, past the resident, to the linen barrel and back across the room and exited the shower room.</p> <p>Resident #108's clinical record was reviewed on 1/15/13 at 12:14 p.m. An admission Minimum Data Set [MDS] assessment, dated 7/3/12, coded the resident with no cognitive impairment and required extensive assistance of one for transfers, and activities of daily living.</p> <p>2. On 1/22/13 at 12:00 p.m., Resident #108 was observed in her room in a wheelchair, visible from the hallway. The Resident's roommate</p>		<p>and federal law. F164 1. A) Resident #108 will be provided privacy by facility staff when receiving personal care including when resident is receiving a shower. Staff will ensure that privacy curtain will be closed during resident shower. Staff will inquire prior to entering shower room that the shower room is available to provide privacy during personal care. B) Resident #108 will be provided privacy by facility staff when resident is receiving sub cutaneous insulin injection. Facility staff will ensure that resident is in an area where the resident can be provided privacy when receiving stated injection. C) Resident #95 will be provided privacy by facility staff when receiving personal care including when resident is receiving a shower. Staff will ensure that privacy curtain will be closed during resident shower. Staff will inquire prior to entering shower room that the shower room is available to provide privacy during personal care. D) Resident #44 will be provided privacy by facility staff when receiving personal care including when resident is receiving a shower. Staff will ensure that privacy curtain will be closed during resident shower. Staff will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>was positioned parallel to the resident in the wheelchair. LPN #3 was observed to administer a sub cutaneous insulin injection in the right upper arm to the resident. The privacy curtain was not pulled around the resident and the door to the resident's room was not closed.</p> <p>3. Resident #95 was interviewed on 1/16/13 at 10:31 a.m. The resident indicated he did not always have privacy during showers as he was removed from shower stall to dry off and there is no barrier to prevent being seen by anyone in the shower room, or entering the shower room. The resident indicated other people come in during the shower at times.</p> <p>Resident #95's clinical record was reviewed on 1/16/13 at 10:42 a.m. The Minimum Data Set [MDS] assessment dated, 12/4/12, coded the resident with no cognitive impairments.</p>		<p>inquire prior to entering shower room that the shower room is available to provide privacy during personal care. E) Resident#13 will be provided privacy by facility staff when receiving personal care including when resident is receiving a shower. Staff will ensure that privacy curtain will be closed during resident shower. Staff will inquire prior to entering shower room that the shower room is available to provide privacy during personal care. 2. All residents that utilize facility shower rooms to receive personal care have the potential to be affected by the alleged deficiency. All residents receiving injections have the potential to be affected by the alleged deficiency. Facility staff received in-servicing regarding Residents Rights to privacy during personal care and medical treatment and Notice of Privacy Information Practices. In-Service completed on February 7 (SEE ATTACHMENT A and B).</p> <p>3. The Director of Staff Development/Designee will review Resident Rights and Notice of Privacy Information Practices (SEE ATTACHMENT A and B) for personal privacy during personal care and medical treatment with current</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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>and new staff. Director of Staff Development/Designee will monitor residents' personal care to promote compliance with residents' rights to privacy during personal care and medical treatment (SEE ATTACHMENT C). Facility will place privacy curtains in designated shower areas to ensure privacy for personal care of residents. 4. The Director of Staff Development/Designee will monitor staff providing resident personal care and medical treatment 3 times per week. (see attachment C) The results of monitoring will be reviewed by the Administrator and reviewed by the QA team monthly as well as quarterly. Monitoring will be reduced in frequency of monitoring when outcomes demonstrate no opportunities to improve or 100% compliance. However , frequency of monitoring will increase if deficiencies or opportunities to improve are noted. Monitoring will continue for a minimum of monthly for 1 year, and will be included in the corpoptate calendar review process with annual review each quarter. This will be continued to assure privacy for resident personal care and medical treatment. Monitoring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>4. Resident #44 was interviewed on 1/16/13 at 10:48 a.m. The resident indicated when receiving a shower in the central middle shower room, the resident was pulled from the shower stall and without privacy curtains, dried and dressed. The resident indicated that staff and other residents were often present.</p> <p>Resident #44's clinical record was reviewed on 1/16/13 at 3:41 p.m. A quarterly Minimum Data Set [MDS] assessment, dated 8/3/12, indicated the resident was independent in making cognitive decisions.</p> <p>5. Resident #13 was interviewed on 1/16/12 at 11:36 a.m. The resident indicated that privacy was not always afforded during showers because privacy curtains were lacking when the staff were assisting the resident with drying and dressing.</p>		<p>will be reported through the facility QA monthly with review of reporting details of opportunities to improve along with action plan development. QA summary as well as quarterly QA statistics and action plan progress will be submitted for regional corporate review. 5. Date of compliance 02/15/2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>Resident #13's clinical record was reviewed on 1/17/13 at 10:35 p.m. An annual Minimum Data Set [MDS] assessment, dated 11/14/12, indicated the resident required "Physical Help" with bathing, and was independent in making cognitive decisions.</p> <p>On, 1/23/13 at 10 a.m., the central middle shower room was noted with two shower stalls. The largest shower stall was identified by CNA #14 as the stall mostly used. The stall was open to the main part of the central shower room and did not have a privacy curtain. The main part of the central shower room lacked privacy curtains including the area around the toilet.</p> <p>A report of in-service training, dated 2/8/12, included, but was not limited to, "The resident has the right to privacy during all of the following: Treatments and nursing care, telephone calls, visits from friends or family...To protect the resident's right to privacy, close the door, the window curtain, and pull the privacy curtains when you are working with her in her room. Also, keep the resident covered as much as possible when performing procedures. The resident also has the right to full visual privacy</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>during times when care is not being given. This means she can close her door or pull the privacy curtain to prevent being seen from the hallway. No other people should be present when you are helping the resident use the bathroom, dress, or complete personal care needs (unless you need help from another staff person)."</p> <p>3.1-(p)(2) 3.1-(p)(4)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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			
F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure the right of the resident to choose what time of the morning the resident will get up for 2 of 4 residents that met the criteria for choices. (Residents # 44 and #108)</p> <p>Findings include:</p> <p>1. Resident #44 was interviewed on 1/16/13 at 10:48 a.m. The Resident indicated they [staff] "Get me up around 5 a.m. They indicate "so many people to take care of." The resident stated, "I've asked if I can sleep in."</p> <p>Resident #44's clinical record was reviewed on 1/16/13 at 3:41 p.m. A quarterly Minimum Data Set [MDS] assessment, dated 5/13/12, indicated the resident was independent in making cognitive decisions, required physical help with transfers and making choices concerning bedtime</p>	F0242	<p>F242 1. A) Resident #44 was asked a time frame that she would prefer to get up in the morning and to be assisted to bed at night. Resident will be assisted with personal care by staff during the time frames requested by the resident. This information will be documented on Resident's Care Plan and C.N.A. Assignment sheet which will supply staff with information indicating resident's specific choice if one is provided by Resident/Responsible Party. (SEE ATTACHMENT D) B.</p> <p>Resident #108 was asked a time frame that she would prefer to get up in the morning and to be assisted to bed at night. Resident will be assisted with personal care by staff during the time frames requested by the resident. This information will be documented on Resident's Care Plan and C.N.A. Assignment sheet which will supply staff with information</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>was somewhat important.</p> <p>During an interview on 1/23/13 at 11:24 a.m., CNA #6 indicated she was caring for Resident #44 today. The CNA stated, "Sometimes [Resident #44] is up when I come in at 6:00 a.m. This morning I got [Resident #44] up at 6:30 a.m. She will indicate she doesn't want to get up yet, but I tell her she will feel better when she gets up and about."</p>		<p>indicating resident's specific choice if one is provided by Resident/Responsible Party. (SEE ATTACHMENT D) 2. All residents have the potential to be affected by the alleged deficiency. Resident /Responsible Party will be asked upon admission and during the Care Plan process for timeframes that the resident would prefer getting up in the morning and being assisted to bed at night. The information will be documented on Resident's MDS, Care Plan and C.N.A. Assignment sheet will supply staff with information indicating resident's choice if provided by Resident/Responsible Party. 3. The Director of Nursing Services /Designee will review and educate staff regarding Resident's rights to make choices. (SEE Attachment A). Social Services Designee/Designee will review with Resident/Responsible Party upon admission, during routine Care Plan meetings and on an as needed basis for timeframes that the resident would prefer getting up in the morning and being assisted to bed at night. Changes will be made to the Resident MDS, Care Plan and C.N.A. assignment sheets as needed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>to ensure resident choices are provided. 4. Director of Nursing Services/Designee will monitor through observation, inquiry with various residents and reviewing C.N.A. assignment sheets 3 times per week to assure residents are given choice of getting up in the morning and going to bed at night. (SEE Attachment E). The results of monitoring will be reviewed by the Administrator and reviewed by the QA team monthly as well as quarterly. Monitoring will be reduced in frequency of monitoring when outcomes demonstrate no opportunities to improve or 100% compliance. However , frequency of monitoring will increase if deficiencies or opportunities to improve are noted. Monitoring will continue for a minimum of monthly for 1 year, and will be included in the corportate calendar review process with annual review each quarter. This is to assure that residents continue to recieve the choice of getting up in the morning and going to bed at night. Monitoring will be reported through facility QA monthly with review of reporting details of oppourtunities to improve along with action plan</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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>2. Resident #108 was interviewed on 1/15/13 at 11:09 a.m. The resident indicated she was not always able to get up in the mornings at the desired time. The resident indicated "they" [the staff] want you up by 7:30 a.m. and she would prefer to get up at 9:00 a.m. or 10:00 a.m. The resident also indicated she sometimes had to wait to go to bed when she wanted depending on what staff were working on her unit.</p> <p>CNA #1 was interviewed on 1/23/13 at 2:00 p.m. The CNA indicated she got the resident up at 6:30 a.m. The CNA indicated sometimes the resident preferred to get up later, but when she did that the resident was not satisfied so she worked it into her routine to get her up at 6:30 a.m.</p> <p>Resident #108's Minimum Data Set [MDS] dated, 7/3/12, coded the resident with no cognitive impairment, very important for resident to choose bed time, and requires limited to extensive for two for activities of daily living.</p>		<p>development. QA summary as well as quarterly QA statistics and action plan progress will be submitted for regional corporate review. 5. Date of compliance: 02/15/2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
	3.1-(u)(1)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review the facility failed to ensure it was free from medication error rates of 5 percent or greater in that 5 errors in the opportunity for 50 errors were observed which resulted in a 10 per cent error rate.[Residents #48 and #108]</p> <p>Findings include:</p> <p>1. On 1/23/13 at 8:53 a.m., LPN #4 was observed to administer medications to Resident #108. The LPN indicated the resident was to receive Azlastine nasal spray each nostril [for allergies] daily, Lasix [diuretic] 80 mg [milligrams] by mouth at 9:00 a.m., and Cranberry 425 mg by mouth [for chronic urinary tract infections] daily. The LPN indicated the medications were not available and would not be in the facility until night shift.</p> <p>The resident's clinical record was reviewed on 1/23/13 at 5:00 p.m. Physician's orders were noted for Cranberry 425 mg po [by mouth] for chronic UTI's [urinary tract infection],</p>	F0332	<p>F332 1. A) Resident #108 Medication Administration Record was reviewed by Unit Manager to ensure that all prescribed medications were present. Needed medications were pulled and administered from the facility Over The Counter Supply and facility contracted pharmacy. B)Resident#48Medication Administration Record was reviewed by Unit Manager to ensure that all prescribed medications were present Needed medications were pulled and administered from the facility Over The Counter supply and facility contracted pharmacy. 2. All residents have the potential to be affected by the alleged deficiency. 3. Director of Nursing Services/Designee in-serviced Licensed Nurses and QMAs on facility Policy and Procedure for STAT medications and facility EDK utilization, Facility Back up Pharmacy and documentation of resident's refusal of medications. Director of Nursing Services/Designee will review resident's Medication Administration Records 2 times</p>	02/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>dated 1/18/13, Azelastine 137 mcg [micrograms] nasal spray 1 spray in each nostril every morning for allergies, dated 10/17/12, and Lasix 80 mg po daily at 9:00 a.m. for congestive heart failure and edema.</p> <p>2. On 1/23/13 at 9:18 a.m., LPN #4 was observed to administer medications to Resident #48. The LPN indicated the resident was to receive Zestril [for hypertension] 2.5 mg by mouth daily and Cranberry extract capsules 425 mg by mouth daily and the medications were not available.</p> <p>Resident #48's clinical record was reviewed on 1/23/13 at 5:10 p.m. Physician's orders included, but were not limited to, Cranberry Extract capsules 425 mg 1 by mouth every day for chronic UTI's dated, 1/18/13, and Zestril 2.5 mg by mouth daily for hypertension.</p> <p>On 1/23/13 at 5:20 p.m., LPN #4 was interviewed. The LPN indicated the medications were not available in the facility and would not be delivered to the facility until the night shift.</p> <p>The Director of Nursing [DON] was interviewed on 1/23/13 at 4:30 p.m. The DON indicated pharmacy</p>		<p>per week for 3 months and then on an as needed basis to identify any discrepancies of unavailable medications or resident refusal of medications. (See Attachments F,A and G) 4.The Director of Nursing Services/Designee will review residents Medication Administration Records 2 times per week. (See Attachment G). The results of monitoring will be reviewed by the Administrator and reviewed by the QA team monthly as well as quarterly. Monitoring will be reduced in frequency of monitoring when outcomes demonstrate no opportunities to improve or 100% compliance. However , frequency of monitoring will increase if deficiencies or opportunities to improve are noted. Monitoring will continue for a minimum of monthly for 1 year, and will be included in the corporate calendar review process with annual review each quarter due to the high risk of high volume related to medication administration. Monitoring will be reported through the facility QA monthly with review of reporting details of opportunities to improve along with action plan development. QA summary as well as quarterly QA statistics and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>delivered medications to the facility from 1 a.m. to 3 a.m. and sometimes it was 5:30 a.m. The DON indicated it was always on third shift. The DON indicated medication could have been obtained from a local pharmacy before closing at 5:00 p.m., or obtained from the emergency drug kit [EDK] if included in the kit. The contents of the EDK included, but was not limited to Lasix 20 mg.</p> <p>3.1-48(c)(1)</p>		<p>action plan progress will be submitted for regional corporate review. 5. Date of compliance: 02/15/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to display the nurse staffing data which included the total number of licensed and unlicensed staff as well as current date for 1 of 1 nurse staffing</p>	F0356	F356 1. A) It is the intent of the facility to meet the Posted Nursing Staffing information required guidelines of the alleged deficiency. (SEE ATTACHMENT H). The facility Director of Nursing	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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>data displayed in the facility. This had the potential to affect all 94 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 1/14/13 at 10:25 a.m., the nurse staffing data for the entire facility posted at the front nursing station was dated 1/11/13. The data was observed not to include the total number of licensed and unlicensed staff. 2. On 1/22/13 at 10 a.m. and on 1/23/13 at 9 a.m., the nurse staffing data posted at the front nursing station was observed not to include the total number of licensed and unlicensed staff. 3. During interview of the Administrator on 1/23/13 at 5 p.m., the Administrator indicated the nurse staffing data posted did not include the total number of licensed and unlicensed staff. 4. The facility's undated policy and procedure for nurse staffing information, identified by the Administrator as current, was reviewed on 1/23/13 at 3:25 p.m. The policy indicated the data requirements must include the current date and the total number of licensed and 		<p>Services/Designee will ensure that required Nurse Staffing information will be posted per state and federal regulations. 2. All residents have the potential to be affected by the alleged deficiency. 3. The Director of Nursing Services/Designee will complete the Nurse Staffing Form (SEE ATTACHMENT H) per state and federal regulations and will be posted per state and federal regulations. Changes to the form will be made on an as needed basis to ensure accurate information is provided per state and federal regulations. 4. The Director of Nursing Services/Designee will monitor the required posting of the Nursing Staff Form through observation and review of Nursing staff schedule. Monitoring will be done on a daily basis. (SEE ATTACHMENT I) The results of monitoring will be reviewed by the Administrator and reviewed by the QA team monthly as well as quarterly. Monitoring will be reduced in frequency of monitoring when outcomes demonstrate no opportunities to improve or 100% compliance. However , frequency of monitoring will increase if deficiencies or opportunities to improve are</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>unlicensed nursing staff which included the categories of registered nurses, licensed practical nurses, and certified nurse aides.</p> <p>3.1-13(i)(4)</p>		<p>noted. Monitoring will continue for a minimum of monthly for 1 year, and will be included in the corporate calendar review process with annual review each quarter to assure that the facility will meet the state and federal guidelines for posting the Nursing Staff Form. Monitoring will be reported through the facility QA monthly with review of reporting details of opportunities to improve along with action plan development. QA summary as well as quarterly QA statistics and action plan progress will be submitted for regional corporate review. 5. Date of compliance:: 02/15/2013</p>		