

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2013
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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00122001.</p> <p>Complaint IN00122001 - Substantiated - Federal/state deficiencies related to the allegation are cited at F315.</p> <p>Survey dates: March 18, 19, 20, 21, 22, 25, 26, 27, and 28, 2013</p> <p>Facility number: 000168 Provider number: 155267 AIM number: 100267020</p> <p>Survey team: Gloria J. Reisert MSW - TC Debbie Peyton, RN Gwen Pumphrey, RN Gordon Tyree, RN (3/26, 3/27, and 3/28/13)</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 9 Medicaid: 41 Other: 10 Total: 60</p>	F000000	<i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i>	

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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 9, 2013 by Cheryl Fielden, RN</p>			

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F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide the liability notices to 3 of 3 Medicare A residents upon discharge to home/hospital although Medicare benefit days were still available. (Resident #69, #84, and #91).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the clinical record for Resident #69 on 3/28/13 at 10:00 a.m., indicated the resident was admitted to the facility on 10/3/12 to receive therapy and was discharged back to the hospital on on 10/23/12. 2. Review of the clinical record for Resident #84 on 3/28/13 at 10:10 a.m., indicated the resident was admitted to the facility on 2/6/13 for therapy and was discharged to home on 3/18/13. 3. Review of the clinical record for Resident #91 on 3/28/13 at 10:20 a.m., indicated the resident was admitted to the facility on 12/17/12 to receive therapy and was discharged to home on 2/7/13. <p>During an interview with the Business Office Manager on 3/26/13 at 10:00</p>	F000156	<p>We respectfully request a face to face IDR due to this tag does not relate to what has been sited. The residents sited were all discharged to home as per their discharge plan. The 2567 indicates Resident #69 went to the hospital. Our records indicate this resident went home. We believe our admission paperwork meets the requirements of this regulation and we do not have a deficient practice. See Exhibits 1, 2, 3, 4, 4A, and 4B. Residents # 69, 84, and 91 have been discharged from the facility. Staff continue to provide the liability notices as per federal regulation, as well as policy and procedure. Business office staff have been re-educated on the liability notice requirements. It is the responsibility of the Business office staff to provide the liability notices. The Business office manager will be responsible for completing and presenting the liability notices as required. The Administrator will review liability notices weekly for 4 weeks, monthly for 3 months, and then quarterly for 3 quarters. Any identified concerns will be immediately addressed, up to and including disciplinary action. The ADM/designee will bring forward the results of the reviews to the Quality Performance Improvement committee monthly</p>	04/26/2013	

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	a.m., she indicated "We do not issue the Medicare letters if they went home. We only issue the letters if they were cut from Medicare or they exhausted their days." 3.1-4(l)(1)		for review. Any further action necessary will be as determined by the QPI committee.	

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview, and record review the facility failed to promptly resolve residents grievances. This deficient practice affected 1 of 1 residents in a sample of 30 (Resident #46).</p> <p>Findings include:</p> <p>During an interview on 3/20/13 at 9:38 a.m., Resident #46 indicated personal items were missing including jewelry and clothing. When asked if staff were notified, Resident #46 reports the SW was made aware the same day the items were missing, but no one had given an update on the status of the missing items.</p> <p>An interview on 3/26/13 at 9:50 a.m., with the SW indicated when residents report missing items, staff are alerted, the report is logged and the item is found or replaced. The SW indicated Resident #46 loses things "all the time" and to her knowledge all items were found. When asked to produce the grievance log for Resident #46 alleged missing items, a log with one</p>	F000166	Resident 46 has been assisted with any missing items, and they have been located within the resident room. A one time review of current resident population has been completed to ensure there are no other unaddressed missing items. Staff have been re-educated on the use of the concern reports and completing the forms with any resident concern. It is the responsibility of Professional Staff to complete a concern form should a resident inform them of missing items. SSD/Designee will be responsible to conduct 10% of current resident population interviews weekly to ensure concern forms are being completed as needed, and followed up on as per policy. The interviews will be conducted weekly for 8 weeks, and then monthly for 10 months. Any issues or concerns identified will be immediately addressed, either by 1:1 re-education, and/or disciplinary action. The ADM/designee will review the results of the resident interviews weekly then monthly. The results of the reviews will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI	04/26/2013			

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	<p>item of dove soap was produced. When asked if there were any other allegations documented, the SW indicated no.</p> <p>A copy of the policy and procedure titled Concern-Resident/Family was received on 3/25/13 at 11:23 a.m., from the Administrator. This policy indicated a Resident Concern Report should be completed for any and all concerns.</p> <p>3.1-7(a)(2)</p>		committee.		

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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to ensure resident were free from mistreatment and abuse. This deficient practice affected 1 of 1 resident in a sample of 30 residents (Resident#97).</p> <p>Findings include:</p> <p>A copy of the policy and procedure titled Prevent and Reporting: Resident Mistreatment, Neglect, Abuse was recieved on 3/25/13 at 10:00 a.m. from the administrator.</p> <p>During an interview with Resident #97 on 3/26/13 at 2:09 p.m., she/he indicated when CNA #1 performs incontinent care CNA #1 is rough with the resident's legs. Resident #97 indicated CNA #1 becomes upset and threatens to "tell therapy" if the resident is incontinent. CNA #1 also punishes Resident #97 by putting the resident to bed after episodes of incontinent per resident. Resident #97 required assistance with activities</p>	F000224	We respectfully request a face to face IDR for the following reasons: The sitation noted in the 2567 indicates a staff member had been notified by the resident at the time the aide had reportedly said something to the resident regarding therapy. However, per the investigation completed, the nurse the resident "reported" the incident to was not scheduled to work that particular evening, nor had the nurse been called into work. (Time Card Detail had been provided to the visiting surveyors as well as staff statements that they had not been notified by the resident of any concern) Upon notification to the ADM by the PHNS of the allegation, we immediately initiated an investigation, suspended the C.N.A for the protection of the resident, and completed the initial report to ISDH. Additionally, the sited tag indicates the surveyors had requested to speak to the RN and C.N.A. To our recollection and note review, there was no request made to the ADM, or any other staff member, to speak with the RN and C.N.A. Furthermore, we	04/26/2013			

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	<p>of daily living(adls) due to diagnosis not limited to stroke. Resident #97 was in fear of not being able to discharge in to the community because of CNA#1's comments. Resident #97 reported allegations to RN #4 immediately after incident and there was nothing was done per resident.</p> <p>During an interview with the Administrator and Social Worker on 3/26/13 2:15 p.m., indicated no prior knowledge of Resident #97 allegations. They both report no investigation was completed.</p> <p>On 3/26/13 at 4:30 p.m. the Administrator reports CNA#1 has been suspended pending the investigation. Resident #97 would be discharged due to insurance reasons, and statements from RN#4, CNA #1 do not substantiate residents claim. When inquired to interview both CNA#1 and RN#4 it was reported they had left the building.</p> <p>Review of Resident #97's closed record on 3/28/13 11:15 a.m. indicated resident was transferred to the hospital on 3/26/13 due to confusion and diarrhea.</p> <p>3.1-28(a)</p>		<p>feel that we did follow the federal regulation and policy and procedure and did not have a deficient practice related to this situation. See Exhibits # 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20. Resident #97 no longer resides at the facility. Interviews with all alert and oriented residents in the facility was completed on 3/25/2013. No other allegations were identified. Staff were re-educated on the facility policy regarding abuse and neglect. It is the responsibility of Professional Staff to follow facility policy and report any allegations of abuse immediately to their supervisor, the DON and the facility Administrator. The SSD/designee will be responsible to conduct 10% of current resident population interviews weekly to ensure no allegations of abuse are unreported. The interviews will be conducted weekly for 8 weeks, and then monthly for 10 months. Any issues or concerns identified will be immediately addressed, either by 1:1 re-education, and/or disciplinary action. The ADM/designee will review the results of the resident interviews weekly then monthly. The results of the reviews will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>		

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to investigate allegations of abuse. This deficient practice affected 1 of 1 residents in a sample of 30 residents (Resident #97).</p> <p>Findings include:</p> <p>A copy of the policy and procedure on Prevent and Reporting: Resident Mistreatment, Neglect, Abuse was recieved on 3/25/13 at 10:00 a.m. from the Administrator. The policy indicates allegations of abuse must be investigated immediately.</p> <p>During an interview with Resident #97 on 3/26/13 at 2:09 p.m., she/he indicated when CNA #1 performs incontinent care CNA #1 is rough with the resident's legs. Resident #97 indicated CNA #1 becomes upset and threatens to "tell therapy" if the resident is incontinent. CNA #1 also punishes Resident #97 by putting the resident to bed after episodes of incontinent per resident. Resident</p>	F000226	<p>We respectfully request a face to face IDR for the following reasons: The sitation noted in the 2567 indicates a staff member had been notified by the resident at the time the aide had reportedly said something to the resident regarding therapy. However, per the investigation completed, the nurse the resident "reported" the incident to was not scheduled to work that particular evening, nor had the nurse been called into work. (Time Card Detail had been provided to the visiting surveyors as well as staff statements that they had not been notified by the resident of any concern) Upon notification to the ADM by the PHNS of the allegation, we immediately initiated an investigation, suspended the C.N.A for the protection of the resident, and completed the initial report to ISDH. Additionally, the sited tag indicates the surveyors had requested to speak to the RN and C.N.A. To our recollection and note review, there was no request made to the ADM, or any other staff member, to speak with the RN and C.N.A. Furthermore, we feel that we did follow the federal</p>	04/26/2013			

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	<p>#97 required assistance with activities of daily living(adls) due to diagnosis not limited to stroke. Resident #97 was in fear of not being able to discharge in to the community because of CNA #1's comments. Resident #97 reported allegations to RN #4 immediately after incident and there was nothing was done per resident.</p> <p>During an interview with the Administrator and Social Worker on 3/26/13 at 2:15 p.m., indicated no prior knowledge of Resident #97 allegations. They both report no investigation was completed.</p> <p>On 3/26/13 at 4:30 p.m. the Administrator reports CNA#1 has been suspended pending the investigation. Resident #97 would be discharged due to insurance reasons, and statements from RN#4, CNA #1 do not substantiate residents claim. When inquired to interview both CNA#1 and RN #4 it was reported they had left the building.</p> <p>Review of Resident #97's closed record on 3/28/13 at 11:15 a.m. indicated resident was transferred to the the hospital on 3/26/13 due to confusion and diarrhea.</p>		<p>regulation and policy and procedure and did not have a deficient practice related to this situation. See Exhibits # 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20. Resident #97 no longer resides at the facility. Interviews with alert and oriented residents in the facility was completed on 3/25/2013. No other allegations were identified. All staff were re-educated on the facility policy regarding abuse and neglect. It is the responsibility of Professional Staff to follow facility policy and report any allegations of abuse immediately to their supervisor, the DON and the facility Administrator. The SSD/designee will be responsible to conduct 10% of current resident population interviews weekly to ensure no allegations of abuse are unreported. The interviews will be conducted weekly for 8 weeks, and then monthly for 10 months. Any issues or concerns identified will be immediately addressed, either by 1:1 re-education, and/or disciplinary action. The ADM/designee will review the results of the resident interviews weekly then monthly. The results of the reviews will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>	

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview the facility failed to provide care for residents in a manner to maintain each resident's dignity. This deficient practice affected 1 of 2 residents in a sample of 30 residents (Resident #97).</p> <p>Findings include:</p> <p>During an interview on 3/26/13 at 2:09 p.m., Resident #97 indicated when CNA #1 performs incontinent care CNA #1 is rough with the resident's legs. Resident #97 indicated CNA #1 becomes upset and threatens to "tell therapy" if the resident is incontinent. CNA #1 also punishes Resident #97 by putting the resident to bed after episodes of incontinence per resident. Resident #97 was in fear of not being able to discharge in to the community because of CNA #1's comments. Resident #97 reported allegations to RN #4 and there was nothing was done per resident. RN #4 was</p>	F000241	<p>We respectfully request a face to face IDR related to the statement in the 2567 Resident #56 was laying on a sheet "yellow tinged". Per staff statement, at the time of the observation, the RN did not see the yellow tinged sheet, and care provided immediately upon identification. We respectfully request a face to face IDR for the following reasons: The situation noted in the 2567 indicates a staff member had been notified by the resident at the time the aide had reportedly said something to the resident regarding therapy. However, per the investigation completed, the nurse the resident "reported" the incident to was not scheduled to work that particular evening, nor had the nurse been called into work. (Time Card Detail had been provided to the visiting surveyors as well as staff statements that they had not been notified by the resident of any concern) Upon notification to the ADM by the PHNS of the allegation, we immediately initiated an investigation, suspended the C.N.A for the protection of the resident, and completed the initial report to ISDH. Additionally, the sited tag</p>	04/26/2013

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	unavailable for interview. 3.1-3(t)		indicates the surveyors had requested to speak to the RN and C.N.A. To our recollection and note review, there was no request made to the ADM, or any other staff member, to speak with the RN and C.N.A. Furthermore, we feel that we did follow the federal regulation and policy and procedure and did not have a deficient practice related to this situation. See Exhibits # 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21. Resident 97 no longer resides at the facility. Resident 56 had his clothing and bed changed on 3/25/2013 at 12:15pm. A one time review of current resident population has been completed to ensure there are no other concerns regarding dignity. Staff have been re-educated on treating residents with dignity and respect. It is the responsibility of staff to treat residents in a dignified and respectful manner. SSD/designee will be responsible to conduct 10% of current resident population interviews to ensure residents are treated with dignity and respect. The interviews will be conducted weekly for 8 weeks, and then monthly for 10 months. Any issues or concerns identified will be immediately addressed, either by 1:1 re-education, and/or disciplinary action. The ADM/designee will review the results of the resident interviews weekly then monthly. The results of the reviews will be forwarded to		

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			the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.	

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview the facility failed to revise the resident's comprehensive plan of care. This deficient practice affected 2 of 3 residents in a sample of 30(Resident #56 and Resident #46).</p> <p>Findings include:</p> <p>1. A review of the medical record for Resident #56 on 3/22/13 at 9:04 a.m., indicated diagnosis including but limited to depression, insomnia, hypertension (high blood pressure), and diabetes. The care plan for this resident indicated a sleep</p>	F000280	Resident #46 and #56 have had their psychotropic medication care plans reviewed and updated. A one time audit of psychotropic medication care plans was completed to review for incomplete care plans. Staff have been re-educated on revising care plans and to follow policy and procedure. It is the responsibility of the IDT (Inter-disciplinary Team) to complete psychotropic medication care plans. The SSD/designee will be responsible to review psychotropic medication care plans for 10% of current population weekly for 8 weeks, then monthly for 10 months. Any identified concerns will be	04/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013	
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	<p>aid, ambien was being given for the diagnosis of insomnia. The care plan was last reviewed on on 1/17/13.</p> <p>An interview with RN #5 on 3/22/13 at 2:00 p.m. indicated Resident #56 was not currently taking Ambien. The current medication record was reviewed with RN #5 and Ambien was not listed. RN#5 indicated this resident has not had Ambien in the last three months.</p> <p>On 3/22/13 at 11:02 a.m., LPN #4 provided a copy of the physician order of when the Ambien was discontinued. The Ambien was ordered to be discontinued on 11/1/12. The care plan was not updated to reflect these changes.</p> <p>2. An interview on 3/20/2013 at 10:43 a.m. with Resident #46 indicated pain when chewing due to partial dentures missing and loose tooth. The resident indicated staff were aware. Resident could not confirm if an appointment with the dentist had been made and reports having these issues for some time.</p> <p>An interview with the Social Worker on 3/25/13 at 950 a.m. indicated she no knowledge of residents need of</p>		<p>immediately addressed, up to and including disciplinary action.ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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	<p>dental services.</p> <p>An interview with LPN #3 on 3/25/13 at 10:50 a.m. indicated Resident #46 had not verbalized complaints of mouth pain. LPN #3 reports unknown if Resident #46 had an appointment scheduled.</p> <p>Review of the medical record on 3/25/13 at 11:00 a.m., indicated Resident #46 had been to the dentist on 11/12/2012 and 2/18/13 per the dentist's progress notes. Documentation was lacking in then care plan regarding change of condition.</p> <p>A copy of the Plans of Care policy was received from the Administrator on 3/25/13 at 11:23 a.m. The policy indicates care plans should be updated to include any changes in resident's condition.</p> <p>3.1-35(e)</p>				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a doctor's order was followed for 1 of 8 residents reviewed for medication administration. (Resident # 32)</p> <p>Findings include:</p> <p>During an observation of medication administration on 3/27/13, at 7:36 a.m., LPN #3 was observed to administer Loratadine (allergy medication) 10 mg (milligrams) to Resident #32.</p> <p>Record review on 3/27/13, at 8:10 a.m., indicated diagnoses including, but not limited to, major depression, hypertension, diabetes mellitus, hyperlipidemia, chronic obstructive pulmonary disease, restless leg syndrome, obesity, history of colon cancer, insomnia, anxiety, and bipolar. Medication reconciliation of doctor's recapitulated orders indicated an order dated 2/21/13 for Claritin 10</p>	F000282	Resident #32 had her medication reviewed for proper labelling and discontinued medication. No concerns were identified. A one time audit of the current population was completed to ensure medications that have stop dates are correctly documented on the MAR. A one time audit was completed for medications that have a temporary change label to ensure the label matches the MAR and the physicians order. Nursing staff have been re-educated on medication administration according to physician orders, handling change orders, use of temporary change label, and following policy & procedure. It is the responsibility of Licensed Nursing Staff to administer medications according to physician orders and appropriately handle change orders. The DON/designee will be responsible to review orders with a stop date weekly for 8 weeks then monthly for 10 months. The DON/designee will be responsible to review change orders weekly for 8 weeks, then monthly for 10 months. Any identified concerns will be immediately addressed, up to and including disciplinary	04/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013	
NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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	<p>mg po (by mouth) daily for 30 days. Recapitulated doctor's orders also indicated a hand written ASD (Automatic Stop Date) of 3/21/13. Stop date should have been 3/24/13 as first dose was administered on 2/22/13 per MAR (Medication Administration Record.)</p> <p>During an interview on 3/27/13, at 8:15 a.m., LPN #3 indicated that Loratadine 10 mg should have been discontinued on MAR after the 3/24/13 dose was given.</p> <p>During medication administration on 3/27/13, at 7:54 a.m., LPN #3 was observed to administer 1 puff of Symbicort (breathing medication) 160-4.5 mcg (micrograms) inhaler to resident #41.</p> <p>Record review on 3/27/13 at 8:20 a.m., indicated diagnoses including, but not limited to, edema, constipation, elevated ammonia, schizoaffective disorder, dementia with behaviors, anxiety, chronic obstructive pulmonary disease, insomnia with depression, history of alcohol abuse, history of uterine cancer. Medication reconciliation of doctor's recapitulated orders indicated an original order date of 3/7/12 for Symbicort 160-4.5 mcg 1 puff BID</p>		<p>action.ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>				

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	<p>(two times daily). An order dated 1/28/13 indicated Symbicort 160-4.5 mcg inhaler to be changed to 2 puffs BID.</p> <p>During an interview on 3/27/13, at 8:30 a.m., LPN #3 indicated that the dose for Symbicort inhaler had been changed to 2 puffs on 1/28/13. Record review of the MAR indicated to give 2 puffs, but labeling on inhaler indicated to give only 1 puff.</p> <p>3.1-35(g)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment. This deficient practice affected 1 of 3 residents observed for incontinent care in a sample of 30 (Resident #97).</p> <p>Findings include:</p> <p>During an observation on 3/28/13 at 3:28 p.m. of incontinent care on Resident #97, CNA #2 wiped peri area back to front with a wet wash cloth, then pat dry with dry wash cloth. CNA #2 then took a second wash cloth took and wiped back to front direction in the genital area and wiped back with out folding over wash cloth or changing wash cloth then patted dry with dry wash cloth. During an interview CNA #2 and CNA</p>	F000315	We respectfully request a face to face IDR related to the statement in the 2567 Resident #56 was laying on a sheet "yellow tinged". Per staff statement at the time of the observation, the RN did not see the yellow tinged sheet. In addition, the resident had just completed the lunch meal, and care was provided upon identification. We feel we did not have a deficient practice related to F 315. See Exhibit # 21. Resident #56 had clothing and bed changed on 3/25/13 @ 1215pm. Resident #97 no longer resides at the facility. A one time review of nursing aide staff competency regarding perineal care was completed. Nursing staff have been re-educated on perineal care. It is the responsibility of the nursing aide staff to provide appropriate perineal care to prevent urinary tract infection. DON/designee will observe perineal care provided by 10% of nursing aide staff on all	04/26/2013			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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	<p>#3 indicated "soap and water" was used to perform pericare and pointed to the soap dispense.</p> <p>This Federal tag was related to Complaint IN00122001</p> <p>3.1-41(a)(2)</p>		<p>shifts weekly for 8 weeks then monthly for 10 months. Any identified concerns will be immediately addressed, up to and including disciplinary action. ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>		

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 10 resident drug regimens reviewed was free of unnecessary psychotropic medication. (Resident #98)</p> <p>Finding included:</p> <p>Review of the clinical record for Resident #98 on 3/27/13 at 7:45 a.m., indicated the resident was admitted from the hospital on 1/21/13 and had</p>	F000329	We respectfully request a face to face IDR regarding this situation for the following reasons: The attending MD did document the reasonings for the medication use in the January 22, 2013 in the history of present illness. The consultant pharmacist did request the attending MD provide a diagnosis, which he did on the 2-11-13 pharmacy recommendation. Furthermore, the 2567 indicates review of the nurses notes failed to show any documentation of behavior symptoms in the medical record	04/26/2013			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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	<p>diagnoses which included, but were not limited to: bilateral stroke with left hemiplegia, tracheostomy, gastrostomy tube placement, history of aspiration pneumonia, depression, gastroesophageal reflux disease.</p> <p>Review of a 2/11/13 Consultant Pharmacy recommendation indicated the physician needed to provide a diagnosis and justification of the clinical condition being treated regarding symptoms and/or behaviors for the use of Seroquel (an anti-psychotic medication). Although the physician gave a diagnosis of Brief Psychotic Disorder for the use of Seroquel, he failed to also list the symptom criteria for the use of the medication during his visit on 2/28/13.</p> <p>On 1/23/13, a Mood and Behavior symptom care plan was developed by Social Work to address potential side effects from psychotropic drug use related to Seroquel use.</p> <p>A review of the nursing notes between 1/21/13 and 3/26/13 failed to locate documentation of any behavior symptoms. Documentation was also lacking by Social Services of any mood/behavior issues to justify the diagnosis of Brief Psychotic Disorder. The 1/28/13 Social Service progress</p>		<p>from 1/21/13 thru 3/26/13. Per our review, there is documentation in the medical record regarding resident behavior symptoms on 1/25/13, 1/26/13, 1/27/13, 1/29/13, 2/2/13, 2/3/13, 2/10/13, 2/16/13, 2/26/13, and 3/10/13. See Exhibits # 32, 33, 34, 35, 36, and 37. Resident #98 had seroquel reviewed by consultant pharmacist and attending physician. A one time audit of current population receiving anti-psychotic medications was completed. Licensed nursing staff have been re-educated on maintaining drug regimens that are free from unnecessary drugs. It is the responsibility of Licensed Nursing Staff and Consult Pharmacist to ensure residents regimens are free from unnecessary drugs. The DON/designee will be responsible to review 10% of current population receiving anti-psychotic medications weekly for 8 weeks, then monthly for 10 months to ensure drug regimens are free from unnecessary drugs. The consultant pharmacist will review recommendations monthly. Any identified concerns will be immediately addressed, up to and including disciplinary action. ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as</p>				

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	<p>note indicated the resident's mood and behaviors were stable with use of medications and psychiatric services were not needed.</p> <p>During an interview with the Social Worker on 3/27/13 at 3:10 p.m., she indicated she had not developed any behavior tracking sheets for Resident #98 as the resident was not displaying any behavior symptoms.</p> <p>On 3/27/13 at 10:30 a.m., the Assistant Director of Nursing presented a copy of the facility's current policy titled "Psychoactive Medication". Review of this policy at this time included, but was not limited to: "...Procedure: 2. Use psychoactive medications for reasons that may include, but were not limited to:...Treatment of documented medically supported psychiatric diagnoses and identified Target Behavior(s).</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>		determined by the QPI committee.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013
NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored and prepared under sanitary conditions on 2 of 5 kitchen observation days, in that expired foods were not discarded from 2 of 2 refrigerators, spoiled food was not discarded from 1 of 2 refrigerators, expired and freezer burned foods were not discarded from 1 of 2 freezers; and foods were not properly labeled in 2 of 2 refrigerators, and 2 of 2 freezers. Food preparation area, serving area, and dish cleaning area floors were dirty; cleaned serving utensils were observed to have food residue on them; and improper hand washing technique was observed. This practice had the potential to affect 60 of 60 residents residing in the facility.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen, on 3/18/13, at 10:25 a.m., with the</p>	F000371	<p>No residents identified. Staff removed expired food from refrigerator and freezer in kitchen. The entire kitchen was cleaned. Repairs were made to holes in wall of dry storage and exterior exit door. Reach-in and walk-in freezers were defrosted. Freezers were serviced. Pest control services were provided. Dietary staff were re-educated prior to working on 3/19/13 regarding sanitation, food storage, hand-washing, and pest control. DM/designee to conduct daily rounds, Monday thru Friday, utilizing the Quick Sanitation Check. Quick Sanitation Check includes: food storage, sanitation, pest control and more. ADM/designee to conduct Quick Sanitation Check twice daily, Monday thru Friday, for 2 weeks then weekly for 6 weeks then monthly for 10 months. Maintenance Director to complete the TELs PM list: walk-in freezer temp, reach-in freezer temp, and further monitor and document the defrosting of the walk-in freezer and reach-in freezer. Pest control services will continue according to monthly</p>	04/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013
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	<p>Assistant Director of Nursing, the walk-in refrigerator was observed to contain: 1 opened bag of chocolate chips with opened date of 6/1/12 and no expiration date, 2 large opened containers of cocktail sauce with a manufactured date of 10/23/12 having mold growing on outside of container, 2 opened containers of Parmesan cheese with no opened dates, 1 ham dated 3/17/13 and loosely wrapped in plastic observed sitting on container of German potato salad and leaking juices onto the lid, 1 opened bag of spoiled shredded lettuce with expiration date of 3/12/13 and no open date was found in the bottom of a box that contained a bag of unopened spinach, 1 unopened bag of salad mix with a use by date of 3/15/13 was observed to have 2 inch area of darkened, watery substance in middle of bag, 3 unopened bags of shredded cabbage in a box with no received date, 3 heads of cabbage observed in a box lid with no received date, 1 box of pasteurized eggs with received date of 10/8/12.</p> <p>The walk-in freezer was observed to contain: 1 opened bag of hamburger patties, 1 opened bag of Salisbury steak, 2 bags of franks, and 1 bag of chicken wings with freezer burn and no opened date; multiple bags of</p>		<p>schedule and as needed visits. Any identified concerns will be immediately addressed, up to and including disciplinary action. ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>		

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>frozen vegetables with no labeling or dates; Zip-Lock bag of beef liver dated 7/13/12.</p> <p>The reach-in freezer was observed to contain multiple bags of whipped topping with no labeling or dates.</p> <p>The reach-in refrigerator was observed to contain: 2 cups of yellow substance with lids and no labeling or dates (Cook #1 was unable to identify substance), 2 cups of fruit with no labeling or dates, 2 cups of fruit cocktail with expiration date of 3/14/13, and orange slices in container with expiration date of 3/14/13.</p> <p>During an interview on 3/18/13 at 10:30 a.m., Cook #1 indicated that boxes of produce were to be dated when received and used by the expiration date on the individual bags and that frozen foods were to be discarded 5 days after opening. Nutrition Services Manager indicated that pasteurized eggs were to be discarded after 30 days.</p> <p>A note was observed on the walk-in freezer door on 3/18/13, at 11:00 a.m., and indicated "Before any food is placed in refrigerator it must be labeled and dated. Please do at all</p>			

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	<p>times. State tag if not done." Note was signed by Nutrition Services Manager.</p> <p>Also on initial tour on 3/18/13, at 10:25 a.m., the floors in food preparation area, serving area, and dish cleaning area were observed to be soiled with brown stains. Dirt, dust and multiple kitchen items observed under counters in serving area.</p> <p>During an observation of food service line on 3/18/13, at 11:50 a.m., dietary aide #1 was observed to leave the kitchen, then re-enter the kitchen to serve beverages on residents trays without washing hands. Same dietary aide was observed to touch face multiple times, and lift garbage lids twice without washing hands. Same dietary aide was observed once to wash hands, then turn off faucet with bare hands.</p> <p>During a kitchen observation on 3/21/13, at 9:50 a.m., with the Nutrition Services Manager, 4 ice cream scoops that had been placed on the condiment cart and ready for food service were observed to have old food residue on them. 2 plates that were stacked in plate warmer were also observed to have food residue on them.</p>				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>A review of the Dietary Services Cleaning Schedule, presented on 3/19/13, at 10:16 a.m., by the administrator, were initialed and indicated that floors are swept and mopped daily.</p> <p>A review of the In-Service Training Record, presented on 3/20/13, at 8:55 a.m., by the administrator, indicated that there was a presentation by the dietary manager on 11/9/12. Objective was "Kitchen floors to be swept and mopped daily 3 X Daily." Indicated that dietary aide #3, cook #2, dietary aide #4, dietary aide #2, dietary aide #1, and cook #1 were in attendance.</p> <p>A policy and procedure for "Freezer Storage" was provided by the administrator on 3/19/13, at 10:16 a.m., and identified as their current policy. The procedure indicated, but was not limited to, "Label products with delivery date (month, day, and year) the product was received."</p> <p>A policy and procedure for "Personal Hygiene" was provided by the administrator on 3/19/13, at 10:16 a.m., and identified as their current policy. The procedure indicated, but was not limited to, "Wash hands</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>properly and as often as needed: Rub hands together vigorously for 15-20 seconds (or according to State regulations), generating friction on all surfaces of the hands and fingers. Rinse hands thoroughly to remove residual soap and then dry. Dry hands with paper towels and turn faucets off with the paper towel. Wash hands after the following activities , including, but not limited to: after touching the hair, face, body, clothing or apron, when returning to work area."</p> <p>3.1-21(i)(3)</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>A. Based on record review and interview, the facility failed to ensure pharmacy recommendations were followed up on by the physician and that the consultant pharmacist followed up with a second request when a recommendation was not completed as directed for 1 of 1 resident reviewed for pharmacy recommendations. (Resident #98)</p> <p>B. Based on observation and record review the facility failed to ensure that the consultant pharmacist reported a discrepancy between a new doctor's order and labeling of the medication to the attending physician, and the director of nursing and that these reports were acted upon. This deficient practice affected 1 of 8 residents observed for medication administration. (Resident #41)</p> <p>Finding includes:</p>	F000428	We respectfully request a face to face IDR regarding this situation for the following reasons: The attending MD did document the reasonings for the medication use in the January 22, 2013 in the history of present illness. The consultant pharmacist did request the attending MD provide a diagnosis, which he did on the 2-11-13 pharmacy recommendation. In addition, the Consultant Pharmacist had noted the reasonings for the medication in the history of present illness located in the medical record, and would not have requested or required a second recommendation to obtain such information. Furthermore, the 2567 indicates review of the nurses notes failed to show any documentation of behavior symptoms in the medical from 1/21/13 thru 3/26/13. Per our review, there is documentation regarding resident behavior symptoms on 1/25/13, 1/26/13, 1/27/13, 1/29/13, 2/2/13, 2/3/13, 2/10/13, 2/16/13, 2/26/13, and 3/10/13. See Exhibits # 32, 33,	04/26/2013	

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	<p>A. Review of the clinical record for Resident #98 on 3/27/13 at 7:45 a.m., indicated the resident was admitted from the hospital on 1/21/13 and had diagnoses which included, but were not limited to: bilateral stroke with left hemiplegia, tracheostomy, gastrostomy tube placement, history of aspiration pneumonia, depression, gastroesophageal reflux disease..</p> <p>A review of a 2/11/13 Consultant Pharmacy recommendation indicated the physician needed to provide a diagnosis and justification of the clinical condition being treated regarding symptoms and/or behaviors. Although the physician gave a diagnosis of Brief Psychotic Disorder for the use of Seroquel (an anti-psychotic medication, he failed to also list the symptom criteria for the use of the medication during his visit on 2/28/13.</p> <p>Review of the 3/11/13 pharmacy review failed to note the pharmacist had made a second recommendation to the physician for document the symptoms for the use of Seroquel.</p> <p>Review of the nursing notes between 1/21/13 and 3/26/13 failed to locate documentation of any behavior</p>		<p>34, 35, 36, and 37. Resident #98 drug regimen was reviewed for other outstanding pharmacist recommendations. Resident #41 had her medications reviewed to ensure accurate labelling. A one time audit of medications with a temporary change label was conducted to ensure the change label matches the MAR and the physicians order. A one time audit of pharmacist recommendations made in the past 60 days was completed to ensure there were no outstanding recommendations. Any outstanding recommendations were reviewed with attending physician. Nursing staff have been re-educated on change order policy & procedure, and use of temporary change label. It is the responsibility of nursing staff to appropriately handle change orders. It is the responsibility of the DON to ensure pharmacist recommendations are acted upon. The DON/designee will be responsible to review 10% change orders weekly for 8 weeks, then monthly for 10 months. The consultant pharmacist will review recommendations monthly. Any identified concerns will be immediately addressed, up to and including disciplinary action. ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any</p>				

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	<p>symptoms. Documentation was also lacking by Social Services of any mood/behavior issues to justify the diagnosis of Brief Psychotic Disorder. The 1/28/13 Social Service progress note indicated the resident's mood and behaviors were stable with use of medication and psychiatric services were not needed.</p> <p>On 3/27/13 at 8:30 a.m., the Administrator presented a copy of the facility's Consultant Pharmacist's Job Description. Review of this Job Description at this time included, but was not limited to: "Summary Description:: Coordinates pharmaceutical services within a long term care facility (facility), in collaboration with facility leadership and staff;...Assists the facility identify, evaluate, and address/resolve pharmacy-related concerns and issues that affect resident care, medical care, quality of life, and/or regulatory compliance...Essential Duties and Responsibilities: Perform Medication Regimen Reviews (MRR), as required by regulation or contract for facility type, and provide written reports of these reviews to applicable facility staff within 5 business days after each month's consulting has been completed; (Name of Software program) software to generate MMR,</p>		further action necessary will be as determined by the QPI committee.				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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	<p>including...recommendations and documents responses to previous recommendations;...Assist the facility in developing and implementing policies and procedures to ensure compliance with federal and state regulations related to ordering, storage, handling, labeling, destruction and administration of drugs and biologicals;...Coordinate or perform review of, using representative sampling, medication storage and labeling in common storage areas (medication carts, medication refrigerators, medication rooms;..."</p> <p>B During medication administration on 3/27/13, at 7:54 a.m., LPN #3 was observed to administer 1 puff of Symbicort (breathing medication) 160-4.5 mcg (micrograms) inhaler to resident #41.</p> <p>Record review on 3/27/13 at 8:20 a.m., indicated diagnoses including, but not limited to, edema, constipation, elevated ammonia, schizoaffective disorder, dementia with behaviors, anxiety, chronic obstructive pulmonary disease, insomnia with depression, history of alcohol abuse, and a history of uterine cancer. Medication reconciliation of doctor's recapitulated</p>						

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>orders indicated an original order date of 3/7/12 for Symbicort 160-4.5 mcg 1 puff BID (two times daily). An order dated 1/28/13 indicated Symbiotic 160-4.5 mcg inhaler to be changed to 2 puffs BID.</p> <p>During an interview on 3/27/13, at 8:30 a.m., LPN #3 indicated that the dose for Symbicort inhaler had been changed to 2 puffs on 1/28/13. Record review of the MAR (Medication Administration Record) indicated to give 2 puffs, but labeling on inhaler indicated to give only 1 puff.</p> <p>Record review on 3/28/13, at 9:45 a.m., indicated that the medication regimen review was completed by consultant pharmacist on 2/11/13 and 3/11/13, and there was no documentation of the dosage change to Symbicort.</p> <p>A policy provided by the administrator, on 3/26/13, at 12:00 p.m., and identified as their current policy indicated, "Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order...If Pharmacy receives a new order that changes the strength or dose of a medication</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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	<p>previously ordered, and there is adequate supply on hand: Pharmacy should discontinue the original order...If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a 'Change in Directions' sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. Facility may order from Pharmacy bulk rolls of 'Change in Directions' stickers."</p> <p>3.1-25(i)</p>				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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F000456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that 2 of 2 freezers were properly maintained and defrosted during 2 of 5 observation days in the kitchen. This deficient practice had the potential to affect 60 of 60 residents in the facility.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen, on 3/18/13, at 11:00 a.m., with the assistant director of nursing, the walk-in freezer was observed to have ice and frost build-up on the ceiling and down onto a box of pork in the back on the top shelf, and also on the condenser and into the left side fan. The reach-in freezer was observed to have approximately 2 inches of frost build-up on the ceiling and on all of the shelves.</p> <p>During an interview on 3/18/13, at 4:25 p.m., the nutrition services manager indicated that ice builds up quickly after defrosting both freezers. He also indicated that there is no</p>	F000456	<p>No residents identified. The entire kitchen was cleaned. Repairs were made to holes in wall of dry storage and exterior exit door. Reach-in and walk-in freezers were defrosted. Freezers were serviced. Dietary staff were re-educated prior to working on 3/19/13 regarding sanitation, food storage, hand-washing, and pest control. Maintenance staff was re-educated regarding maintenance of freezers and pest control. DM/designee to conduct daily rounds, Monday thru Friday, utilizing the Quick Sanitation Check. Quick Sanitation Check includes: food storage, sanitation, pest control and more. ADM/designee to conduct Quick Sanitation Check twice daily, Monday thru Friday, for 2 weeks then weekly for 6 weeks then monthly for 10 months. Maintenance Director to add to TELSPM list: walk-in freezer temp, reach-in freezer temp, and further monitor and document the defrosting of the walk-in freezer and reach-in freezer. Pest control services will continue according to monthly schedule and as needed visits. Any identified concerns will be immediately addressed, up to and including disciplinary</p>	04/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013
NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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	<p>preventative maintenance program for the freezers and that he did not know when the last time either freezer had been defrosted. He indicated that he did inform maintenance about a month ago of the problem in the walk-in freezer and maintenance informed him that someone else would have to look it. He also indicated that there has been no refrigeration specialist in to evaluate the problem.</p> <p>During an interview on 3/18/13, at 4:30 p.m., the maintenance supervisor indicated that there is no preventative maintenance program for the freezers and that both freezers are defrosted as necessary. He indicated that he checks the temperatures on both freezers routinely and that he has defrosted the walk-in freezer, but was unsure of the last date that it was completed.</p> <p>During an observation of the kitchen, on 3/1/9/13, at 7:00 a.m., the walk-in freezer was observed to continue to have ice and frost build-up. The nutrition services manager indicated that he was unsure when maintenance would be defrosting this freezer.</p> <p>During an observation of the kitchen,</p>		<p>action.ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2013
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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>on 3/20/13, at 10:30 a.m., the walk-in freezer was observed to be free from ice and frost build-up and the reach-in freezer was observed to be free from frost.</p> <p>During an interview on 3/20/13, at 3:00 p.m., the nutrition services manager indicated that the maintenance supervisor had removed the ice build-up and frost from both freezers on the previous day, and that this task has been removed from dietary responsibility.</p> <p>During an interview on 3/20/13, at 3:10 p.m., the maintenance supervisor indicated that he had used heat guns to remove the ice and frost from both freezers, and that he did not know what had caused ice to form in the walk-in freezer. He also indicated that he would contact a refrigeration technician to come and look into this issue. He indicated that his records of maintenance repair were not in good shape and that he could not find documentation of when he last defrosted either freezer.</p> <p>During an interview on 3/21/13, at 9:45 a.m., the maintenance supervisor indicated that the "end cover" that encloses air to defrost the condenser unit has been off since</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>April of 2012. He indicated that he did not realize that the absence of this "end cover" would be a problem. He indicated that the refrigeration technician indicated that the left fan is not working on the condenser unit and needs to be replaced and has been ordered. He indicated that after the fan is replaced, he will be able to replace the "end cover".</p> <p>During an interview on 3/21/13, at 9:45 a.m., the refrigeration technician indicated that when the fan and the "end cover" were replaced on the condenser unit, the walk-in freezer would self-defrost every 6 hours. He also indicated that the reach-in freezer did not have a self-defroster and that the shelves were the freezing coils. He indicated that it was acceptable to let frost build up to about 1 inch on these shelves before defrosting.</p> <p>A review of the Dietary Services Cleaning Schedules from October of 2012 through March of 2013, presented on 3/19/13, at 10:16 a.m., by the administrator, indicated that the reach-in freezer was to be defrosted as needed. There were no initials indicating that this task had been completed on any of these schedules.</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>A review of the Maintenance records (documented on spiral notebook), presented on 3/22/13, at 9:00 a.m., by the maintenance supervisor, indicated "walk-in freezer-check fan motor? Defrost-iced up" on 6/25/12 and "defrost walk-in cooler" on 9/5/13.</p> <p>A review of the Position Description for the Maintenance Supervisor, presented on 3/28/13 at 1:25 p.m., by the business office assistant, indicated that essential functions included, but were not limited to, "Preventative Maintenance: Establishes preventative maintenance schedules and keeps accurate records of maintenance performed."</p> <p>Review of the position Description for the nutrition services manager, presented on 3/28/13 at 1:25 p.m., by the Business office assistant, indicated essential functions included, but were not limited to, "Demonstrates proper use of equipment, reports equipment needs or repairs, reports all hazardous conditions/equipment to supervisor."</p> <p>3.1-19(bb)</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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F000469 SS=E	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure that the facility was free of rodents during 3 of 5 kitchen observation days. This deficient practice had the potential to affect 60 of 60 residents in the facility.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen, on 3/18/13, at 11:00 a.m., multiple mouse droppings were observed on the floor under all shelving units in the dry storage room. Multiple glue traps and black baited boxes were also observed under the shelving units. One glue trap was observed on the second shelf from the floor next to a box of food. Droppings were also observed in the left corner of the food service area.</p> <p>During an interview on 3//18/13, at 11:05 a.m., Cook #1 indicated that there was a mouse problem, but that "they have not noticed anything for a</p>	F000469	No residents identified.The entire kitchen was cleaned. Repairs were made to holes in wall of dry storage and exterior exit door. Pest control services were provided. All dietary staff were re-educated prior to working on 3/19/13 regarding sanitation, food storage, hand-washing, and pest control. Maintenance staff was re-educated regarding freezer maintenance and pest control.DM/designee to conduct daily, Monday thru Friday, rounds utilizing the Quick Sanitation Check. Quick Sanitation Check includes: food storage, sanitation, pest control and more. ADM/designee to conduct Quick Sanitation Check twice daily, Monday thru Friday, for 2 weeks then weekly for 6 weeks then monthly for 10 months. Pest control services will continue with monthly schedule and as needed visits. Any identified concerns will be immediately addressed, up to and including disciplinary action.ADM/designee will review the results of the audits weekly then monthly. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.	04/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/28/2013	
NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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	<p>week or so."</p> <p>During a second observation of the kitchen, on 3/18/13, at 4:00 p.m., multiple mouse droppings continue to be observed in the dry storage room. Also a dead mouse was observed on a glue trap in the left corner, under shelving unit, of the same room. Multiple droppings and a black bait box was observed under the steam table.</p> <p>During an interview on 3/18/13 at 4:10 p.m., the nutrition services manager indicated that they have had a mouse problem for about 1 month and that they have not noticed any problems lately. He also indicated that they had only found droppings and cleaned them up when they were found. When he was shown droppings and the dead mouse in the dry storage he indicated at that time that there was a hole in that area where pieces of insulation had been pulled out. He also indicated that they had previously noticed a hole up close to the ceiling around an electrical box which since that time had been patched. Also observed was part of a door frame that was missing near the floor, on door going out to the back of the facility. This hole had been patched with a piece of</p>						

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>concrete like substance and a black bait box was placed outside this door as this is where they determined the mice might be entering the building.</p> <p>During an interview on 3/18/13, at 4:35 p.m., the administrator indicated that the mouse problem was identified by the consulting dietician about a month ago and that Pest Control was notified and started treatment.</p> <p>A review of the Pest Control invoice, presented by the administrator, on 3/25/13, at 9:46 a.m., and dated 3/6/13, indicated that they received a phone call on 3/4/13 for mice in the kitchen and that treatment was on 3/6/13. Kitchen and pantry were baited. 5 bait traps and glue boards were placed in pantry, kitchen, and both sides of serving line. Also a bait box was located outside, behind coke machine.</p> <p>3.1-19(f)(4)</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170			
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F000500 SS=E	<p>483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>Based on record review and interview, the facility failed to develop and maintain a collaborative agreement between the dialysis center and the facility to determine what services each center/facility will provide to 4 of 4 dialysis residents. (Residents #9, #12, #50 and #76)</p> <p>Findings include:</p> <p>1. A review of the clinical record for Resident #9 on 3/25/13 at 9:55 a.m., indicated the resident was admitted from the hospital on 10/17/12 and was discharged back to the hospital on 11/6/12 with a diagnosis of</p>	F000500	Resident #9, #12, #76 no longer reside at the facility. Resident #50 continues to receive dialysis. Agreements between dialysis centers and facility are in-place for in-house dialysis residents. ADM/designee will complete a quarterly audit times three quarters to validate dialysis agreements are in place between facility and dialysis centers that provide service to our residents. Any identified concerns will be immediately addressed. The results of the audits will be forwarded to the QPI committee monthly. Any further action necessary will be as determined by the QPI committee.	04/26/2013			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>elevated ammonia levels. Diagnoses included, but were not limited to: end stage renal disease, end stage liver disease, chronic anemia, diabetes mellitus 2, congestive heart failure, hypertension, and cirrhosis.</p> <p>During interview with the Administrator on 3/26/13 at 3:00 p.m., she indicated that the facility legal department and [name of dialysis center] were in the process of finalizing a contract between both centers, but there was not a current contract in place. She also indicated that she has searched her office, other offices, called the corporate office and was unable to locate a contract between the facility and the dialysis center which was in place at the time Resident #9 resided in the facility.</p> <p>2. A review of the clinical record for Resident #12 on 3/27/13 at 9:00 a.m., indicated the resident was re-admitted from the hospital on 3/26/13 and had diagnoses which included, but were not limited to: deep vein thrombosis, end stage renal disease, hypoglycemia, diabetes mellitus, and gastroesophageal reflux disease.</p> <p>3. A review of the clinical record for</p>			

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
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	<p>Resident #50 on 3/27/13 at 9:30 a.m., indicated the resident was admitted on 12/16/11 and had diagnoses which included, but were not limited to, hypertension, renal failure, diabetes mellitus, and hyperlipidemia.</p> <p>4. A review of the clinical record for Resident #76 on 3/27/13 at 9:45 a.m., indicated the resident was admitted to the facility on 2/17/13 and had diagnoses which included, but were not limited to: pneumonia, renal insufficiency, renal mass, and diabetes mellitus.</p> <p>During an interview on 3/27/13 1:35 p.m., the Administrator indicated, "I have scoured my office, checked with both our corporate office and with the other dialysis center - no one has a current agreement/contract between the facility and the dialysis center for Resident #12, #50 and #76."</p> <p>On 3/25/13 at 11:23 a.m., the Administrator presented a copy of the facility's current policy on "Dialysis Management". Review of this policy at this time included, but was not limited to: "...Contractual Agreement will include, but may not be limited to, the following: Medical emergencies,...Interchange of</p>				

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NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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	<p>information useful/necessary for the care of the resident;...3. Obtain a clear understanding of roles and responsibilities between the facility and the dialysis center and define in writing. This will include, but is not limited to, the following: a. responsibility of monitoring lab values; b. How physician's orders will be validated' c. How provider orders will be communicated between nursing staffs..."</p> <p>3.1-13(m)(1) 3.1-13(m)(2) 3.1-13(m)(3)</p>			