

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey. This survey included Investigation of Complaint IN153807.</p> <p>Complaint Number: IN153807 Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: 8/11, 12, 13, 14, 18, 2014</p> <p>Facility Number: 000555 Provider Number: 155370 AIM Number: 1002675530</p> <p>Survey Team: Denise Schwandner, RN TC Diana Perry, RN Anna Villain, RN</p> <p>Census Bed Type: SNF/NF: 67 Total: 67</p> <p>Census Payor Type: Medicare: 6 Medicaid: 46 Other: 15 Total: 67</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p>	F000000		

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: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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
F000241 SS=E	<p>Quality review completed on August 19, 2014 by Jodi Meyer, RN</p> <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, interview, and record review, the facility failed to ensure each resident's dignity was enhanced and/or respected, in that, residents had to wait to be assisted with the their meal and/or residents were observed with visible body fluids on their clothes and adaptive equipment, for 4 of 19 residents observed during the morning and noon meals. (Resident #36, 10, 13, 60).</p> <p>Findings include:</p> <p>On 8/11/14 the noon meal was observed, the following was observed:</p> <ol style="list-style-type: none"> At 11:43 a.m., Resident #36 was observed in the dining room slouched over in the wheelchair. A liquid substance was observed to be dripping from Resident #36's mouth. At 11:48 a.m., Resident #10 was observed to reach in her mouth and pull 	F000241	<p>Please accept this Plan of Correction as our Allegation of Compliance. Identified residents medical records were reviewed for any negative outcomes with none noted 8-25-14. Residents identified as needing assistance with dining have been further assessed with table assignments updated to ensure proper and timely assistance being rendered 8-25-14. Staff to be re-educated by Director of Clinical Services and or Assistant Director of Clinical Services on proper and timely assistance to those needing such during meal service 9-5-14. Director of Clinical Services and or designee will observe meal service weekly times 12 weeks, then monthly for 12 months to ensure accuracy and make revisions as needed. Tracking and trending will be brought to Risk Management/Quality Improvement Committee monthly for 12 months for further review and further recommendations as warranted.</p>	09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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>out a white phlegm like substance and place it on the wheelchair and clothing. A staff member touched the wheel chair where the phlegm was, the staff member immediately watched their hands and left the phlegm on the chair.</p> <p>On 8/14/14 the breakfast meal was observed, the following was observed:.</p> <p>5. Resident #46 and Resident #13 were seated at table 5. At 6:32 a.m., Resident #46 was served breakfast. Resident #13 was not served until 6:46 a.m.</p> <p>6. Resident #60, Resident #75, and Resident #52 were seated at table 2. At 6:40 a.m., CNA #2 was observed to serve all three residents. At 7:03 a.m., CNA #3 was observed to assist Resident #60 with the meal.</p> <p>7. Resident #36 and Resident #6 were seated at table 8. At 6:43 a.m., Resident #36 was observed to have breakfast tray sitting in front of her. At 6:48 a.m., CNA #2 was observed to assist Resident #6 with the meal. At 7:00 a.m., CNA #2 assisted Resident #36 with the breakfast meal.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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
F000431 SS=E	<p>On 8/18/14 at 12:47 p.m., CNA #1 indicated each resident at the table is served and then staff begins serving another table. CNA #1 further indicated residents requiring assistance are seated together.</p> <p>On 8/18/14 at 1:16 p.m., the Administrator provided the Enhanced Dining and Dining Choice Meal Service policy. The policy indicated, " Residents are served in table order...."</p> <p>3.1-3(t)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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>establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of and medication carts were not clean and orderly, in 2 of 3 medications carts reviewed, (Alzheimer's unit, 100 hall). (Resident #69, #14, #72, #52)</p>	F000431	<p>Identified residents medical records have been reviewed with no negative outcomes noted. 8-25-14. Medication carts have been inspected for expirations, labeling and open dates, and cleaning with corrections being made as needed 8-26-14. Licensed Staff will be re-educated on medication cart</p>	09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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>Findings include:</p> <p>On 8/18/14 at 9:42 a.m., the medication cart on the Alzheimer's unit, was observed:</p> <ol style="list-style-type: none"> 1. A package of Naproxen 220mg, to be given twice a day prn (as needed) for pain, with an expiration date of 7/14, for Resident #69. 2. A bottle of Artificial Tears, two drops each eye, twice a day, for Resident # 14, was observed to have an open date of 7/8/14. The Pharmacist was called by RN # 1 indicated eye drops were good for 30 days after being opened and then they should be discarded. RN #1 also indicated expired medications should be sent back to pharmacy or discarded, and the Articial Tear drops are good for 30 days after opening. 3. The Medication cart drawers were observed with dirt and debris. On 8/18/18 at 9:40 a.m. LPN # 2 indicated medication carts are to be cleaned daily. 4. On 8/18/14 at 9:45 a.m. the medication cart on 400 hall, was found to have drawers with debris and dirt. 		<p>cleaning schedule, expirations, labeling and open dates. 9-5-14Director of Clinical Services and or Assistant Director of Clinical Services will inspect medication carts weekly times 12 weeks, then monthly for 9 months to ensure accuracy and revise as needed with tracking and trending being noted. Tracking and trending to be brought to Risk Managment /Quality Improvement Committee monthly for 12 months for further review and recommendation as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2014	
NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631			
(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>On 8/18/14 at 10:34 a.m. the medication cart was observed, on the 100 hall:</p> <p>5. A bottle of Combigan Sol 0.2-.25%, with the directions to instill 1 drop into each eye twice daily for Resident # 72. The expiration date was 10/15, it was dispensed 1/16/14. The bottle had been opened, with no open date on the bottle.</p> <p>6. A bottle of Refresh Tears 0.5%, 1 drop in each eye, 3 times a day, for Resident # 52. This bottle was dispensed on 7/11/14. The expiration date on the bottle was 1/16/15. The bottle was observed to be opened, and there was no open date on bottle.</p> <p>7. The medication cart was observed with debris and dirt in drawers.</p> <p>RN #1 indicated that the expiration date should be put on all bottles when opened, and expire in 30 days after opening, per policy.</p> <p>On 8/18/14 at 1:17 p.m. a policy For Storage and Expiration of Medications, Biological's, Syringes and Needles was received from the Administrator which indicated : 5) Once a medication or biological package is opened, the Facility should follow manufacturer/supplier guidelines with respect to expiration</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
--	--

(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>dates for open medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.</p> <p>ON 8/18/14 at copy of the Medication Room Cleaning Schedule was received by the ADoN on 8/18/14 at 3:30 p.m. which indicated Medication carts are to be cleaned and straightened by everyone, all shifts. The medication carts are to be checked for expired medication and treatments items daily.</p> <p>3.1-25(o) 3.1-25(m)</p>			