

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2014
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 8, 9, 10, 13, 14, and 15, 2014.</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 10273330</p> <p>Survey team: Lora Brettnacher, RN-TC Connie Landman, RN Mary Weyls, RN (January 9, 10, 13, 14, and 15, 2014) W. Chris Greeney, QIDP (January 13, 14, and 15, 2014)</p> <p>Census bed type: SNF: 2 SNF/NF: 114 Total: 116</p> <p>Census payor type: Medicare: 13 Medicaid: 91 Other: 12 Total: 116</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending January 15, 2014. Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 01/322/2014 by Brenda Marshall, RN.		<p>The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me.</p> <p>Respectfully,</p> <p>Steve Kassen</p> <p>Administrator</p>	

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F000156 SS=D	<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 record review and interview, the facility failed to ensure Medicare Non-Coverage notification was given in a timely manner for 1 of 4 residents reviewed who met the criteria for notification for non-coverage for Medicare services. (Resident #1)</p> <p>Findings include:</p> <p>Interview with the Business Office Manager on 1/15/2014 at 10:16 A.M. indicated Resident #1 had been discharged from Medicare services after 64 days because the facility had determined the resident achieved full potential. However the resident continued to reside at the facility. Review of a spreadsheet with the heading "Skilled Medicare A" provided during the interview by the Business Office Manager indicated Resident #1 had been discontinued from Medicare services on August 29, 2013. The Office Manager stated the resident's status changed from skilled to intermediate care on that date because it was determined the resident would no longer benefit from services.</p> <p>Review 1/15/14 at 11:30 AM of a</p>	F000156	<p>The facility respectfully requests this citation be reviewed. The 2567 for F 156 states, "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 at 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." The 2567 further states, "The facility failed to ensure Medicare Non-Coverage notification was given in a timely manner for 1 of 4 residents reviewed who met the criteria for notification for non-coverage for Medicare Services. The facility contends that the Medicare Non-Coverage notification was provided, explained and signed by resident #1 on 8/26/13, (see attachment 1). This was completed in a timely manner as the effective date for his skilled nursing service ended on 8/28/13. Plan of correction: 1. Resident # 1 was affected. The Medicare Non-Coverage notification form was provided explained and signed by resident</p>	01/31/2014

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	<p>facility document entitled "SNF (Skilled Nursing Facility) Notices of Non-Coverage Cheat Sheet" dated 8/31/12, indicated when a "beneficiary drops to a non-skilled level and benefits have not exhausted and beneficiary remains in the facility, the facility needed to complete a "Notice of Medicare Non-Coverage" form. The Office Manager indicated the form, which disclosed the resident's right to request a review or appeal of the facility's determination, had not been completed for Resident #1.</p> <p>3.1-4(a)</p>		<p>#1 on 8/26/13. 2. All residents who meet the criteria for notification for non-coverage for Medicare coverage have the potential to be affected. 2. All residents who meet such criteria were reviewed to ensure the notification for non-coverage for Medicare coverage completed timely. The Business Office Manager was in-serviced on providing notification for non-coverage for Medicare coverage, (see attachment A). 3. As a measure of ongoing compliance the Business Office Manager will review all residents receiving Medicare coverage weekly ongoing to ensure the proper notification for Medicare Non-Coverage notification is provided timely, (see attachment B) and report continued compliance therewith to the administrator on a weekly basis. 4. As a measure of quality assurance, the Business Office Manager or designee will review any findings and subsequent corrective action as a result of aforementioned auditing in the quarterly quality assurance meeting. The plan will be revised, if warranted.</p>		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were allowed to make choices regarding their plan of care and/or treatment for 1 of 18 residents reviewed for choices (Resident #98).</p> <p>Findings include:</p> <p>During an observation on 1/8/2014 at 2:30 P.M., half side rails were observed in the up position on both sides of Resident #98's bed.</p> <p>Resident #98's record was reviewed on 1/13/2014 at 12:53 P.M. Resident #98 had diagnoses which included, but were not limited to, depression and aphasia. A quarterly MDS [Minimum Data Assessment Tool] dated 10/6/13, indicated Resident #98 was independent with supervision with all activities of daily living and his cognitive status was intact with a BIMS [Brief Interview</p>	F000242	<p>1. Resident # 98 was affected. Upon being informed that resident # 98 preferred not to have ½ side rails, they were removed from his bed. 2. All residents utilizing side rails have the potential to be affected. Side rail screens, (which include the resident's preference for side rails)have been reviewed and updated on all residents, (see attachment C). Upon completing the side rail screen the care plans will be reviewed and revised as appropriate. All residents' preferences on side rail use will be honored.3.As a measure of ongoing compliance, the Unit Manager or designee will complete side rail screens on all residents upon admission, with significant changes, and quarterly ongoing to ensure the residents' preference for side rail use is honored. Should revisions be warranted based on resident response, the same shall be completed and communicated to the DON 4. As a measure of quality assurance the DON or designee will review any revisions and confirm subsequent</p>	01/31/2014	

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	<p>Mental Status] score of 13 out of 15.</p> <p>During an interview on 1/8/2014 at 2:31 P.M., Unit Manager Licensed Practical Nurse [LPN] #4 stated, "I wasn't aware he didn't want them but I think he has a POA [Power of Attorney] who signed consent for them."</p> <p>During an interview on 1/8/2014 at 2:33 P.M., with LPN #4 and LPN #5 present, LPN #4 asked LPN #5 if she was aware Resident #98 did not want the side rails. LPN #5 stated, "He tells me all the time he doesn't want them but like [LPN #4 named] said I thought it was a mandatory thing."</p> <p>During an interview on 1/8/2014 at 2:40 P.M., Resident #98 indicated he did not want the side rails in the up position and he had told staff several times but they would not let him put them down.</p> <p>During an interview on 1/15/2013 at 11:30 A.M., the Director of Nursing [DON] indicated Resident #98 had the right choose whether he did or did not use side rails.</p> <p>An undated document titled "Your Rights as a Nursing Home Resident"</p>		<p>corrective action. Said revisions/actions will be reviewed in the facility's quality assurance meeting held at least quarterly. The plan will be revised, if warranted.</p>				

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F000247 SS=D	<p>provided by the Administrator and identified as part of the admission packet provided to all residents on admission on 1/14/2014 at 2:07 P.M., indicated, "...You have a right to: Participate in designing your plan of care/treatment.... Refuse any plan of care, treatment, or procedure...."</p> <p>3.1-3(u)(1)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident was given notice prior to roommate changes for 1 of 1 resident reviewed for notices prior to change in room or roommate (Resident #98).</p> <p>Findings include:</p> <p>Interview with Resident #98 on 1/8/14 indicated the resident had not been informed in advance when roommates were being moved to and from his room. At the time of the interview the resident did not have a</p>	F000247	<p>1. Resident # 98 was affected. Resident # 98 did not have a roommate at the time of interview. 2. All residents have the potential to be affected. Residents with a revision in roommate will be notified with such documented per the facility policy. Social Services staff will be in-serviced on the facility's policy on intra/inter facility transfers, (see attachment D). 3. As a measure of ongoing compliance the SSD or designee will maintain an audit/log, (see attachment E) weekly ongoing to confirm all residents receiving room mates and/or with a room-mate relocating are notified</p>	01/31/2014			

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	<p>roommate. Resident #98 stated, "They (roommates) leave and they come, no notice."</p> <p>Interview with the Social Services Consultant on 1/14/14 at 2:10 P.M. indicated the facility completes intrafacility transfer forms for the residents that are moving, and they given the right to waive to 48 hours notice. "We would document in progress notes if there was a roommate change." Review of Resident #98's Social Services progress notes dating back to October 31, 2012 indicated no documentation that Resident #98 had a roommate change, had been informed of roommate changes or provided any social services regarding preparation or adjustment regarding such changes. Further interview with the SSC on 1/14/14 at 3:25 P.M. indicated there had been two roommates in the past year in resident #98's room. The SSC confirmed the roommate changes had not been documented in resident #98's medical record.</p> <p>Review on 1/14/14 at 2:00 P.M. of the facility's policy on Intrafacility Transfer, dated September 2008 indicated "Social Service staff will notify the current and new</p>		<p>with such documented. 4. As a measure of ongoing compliance the SSD or designee will report continued compliance via completion of the aforementioned audit/log during the quarterly quality assurance meeting. The plan willbe revised, if warranted.</p>		

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F000329 SS=D	<p>roommates and their families and document in the medical record."</p> <p>3.1-3(v)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 interview and record review, the facility failed to ensure behavioral interventions were implemented prior to the administration of as needed anti-anxiety medication for 1 of 5</p>	F000329	<p>1. Resident # 53 was affected. There was no harm. Resident # 53 received medications as ordered. 2. All residents utilizing PRN psychotropic medications have the potential to be affected. All PRN flow sheets were</p>	01/31/2014	

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	<p>residents reviewed for unnecessary medications (Resident #53).</p> <p>Findings include:</p> <p>Resident #53's record was reviewed on 1/15/2013 at 8:55 A.M. Resident #53 had diagnoses which included, but were not limited to, pain, skin eruptions, and hemiparesis. A quarterly Minimum Data Set Assessment Tool [MDS] dated 10/9/13, indicated Resident #53 was cognitively intact with a BIMS [Brief Interview Mental Status] score of 15 out of 15.</p> <p>An untimed physician's order dated 10/10/13, indicated 0.5 mg [milligram] of Ativan should be administered as needed for anxiety every 8 hours.</p> <p>A care plan dated 1/6/2014, indicated Resident #53 required anti-anxiety medication to treat anxiety. The care plan indicated Ativan [anti-anxiety] medication] 0.5 milligrams [mg] would be administered every eight hours as needed for anxiety. The care plan lacked non-pharmacological interventions.</p> <p>Resident #53's medical record</p>		<p>reviewed to identify any other concerns with non-pharmacological interventions attempted prior to administration of psychotropic medications with such documented. All Nurses will be in-serviced on PRN psychotropic medication use which requires interventions, other than medication, be attempted and documented prior to administration, (see attachment F). 3. As a measure of ongoing compliance, the DON or designee will complete an audit, (see attachment G) daily on regularly scheduled days of work for 30 days, then weekly for 60 days, then monthly ongoing to ensure other interventions are attempted and documented prior to administration of PRN psychotropic medication administration. Should non-compliance be noted, corrective action shall be taken 4. As a measure of quality assurance theDON or designee will report results of the aforementioned audits, any findings, and subsequent corrective actions taken during the facility's quarterly quality assurance meeting. The plan will be revised, if warranted.</p>				

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	<p>indicated staff at times documented the administration of the as needed Ativan on the behavioral flow sheet and not the MAR or in the MAR and not the behavioral flow sheets. The behavioral flow sheets and the MARs from October 13, 2013, through January 15, 2014, were reviewed. These records indicated Resident #53 was administered Ativan 0.5 mg for anxiety 40 times. The record lacked documentation non-pharmacological interventions were attempted prior to the administration of the as needed anti-anxiety medication.</p> <p>During an interview on 1/15/2014 at 9:50 A.M., Licensed Practical Nurse [LPN] #5 stated, "[Resident #53] named ...a lot of time she gets worked up because of pain and she works herself into a panic attack..." LPN #5 indicated at times rubbing her hand, redirecting with television, or calling her family would temporarily relieve her anxiety.</p> <p>During an interview on 1/15/2013 at 10:12 A.M., Resident #53 stated, "No, they don't try anything to relieve the anxiety other than medicine... the medication does work. I have pain. That's all I know. Not sure where the anxiety comes from...."</p>			

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	<p>During an interview on 1/15/2013 at 10:17 A.M., the Administrator was asked to provide documentation which indicated non-pharmacological interventions had been attempted prior to the administration of the as needed anti-anxiety medication.</p> <p>During an interview on 1/15/2014 at 11:06 A.M., The Director of Nursing [DON] indicated non-pharmacological interventions should be part of the residents care plan and should be attempted prior to administering PRN [as needed] anti-anxiety medications. The DON indicated she expected staff to document these interventions in the resident's record and no further documentation was available.</p> <p>An undated policy titled "Medication Administration Policy and Procedure" provided by the DON and identified as current on 1/15/2014 at 11:15 A.M., indicated, "Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations...PRN medications administration must be authorized by a licensed nurse, after completing an assessment.</p>			

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	Documentation should include non-pharmacological interventions attempted prior to resorting to medication administration...." 3.1-48(b)(2)			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and clinical record review the facility</p>	F000441	1. Resident # 43 and # 121 were affected. The residents were not	01/31/2014	

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	<p>failed to ensure proper sanitation/care of glucometers (meter to test blood sugar for 2 of 2 residents observed receiving blood sugar monitoring. (Resident #'s 43 and 121)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 1/14/14 at 11:20 a.m., LPN #2 performed a blood sugar test on resident #121. The nurse entered resident #121's room with a small black bag. The nurse laid the bag on the resident's bed and removed a glucometer (meter to test blood sugar), wiped the glucometer with a "Gluco-Chlor" wipe (bleach wipe) and then immediately wiped the glucometer off with a Kleenex. After the blood sugar testing the nurse wiped the meter with a new bleach wipe and placed the meter back in the black bag. The bag was then placed on the top of the med cart. On 1/14/14 at 11:33 a.m., LPN #3 entered resident # 43's room with a small black bag. The nurse laid the bag on the resident's bedside table and removed a glucometer. After cleansing the meter with a "Gluco-Chlor" towelette, the nurse laid the meter on a paper towel, 		<p>harmd. Blood glucose checks were obtained as ordered. The nurses involved were immediately re-educated on the facility's policy on completing blood glucose checks and infection control practices. Timers were placed on each medication cart to utilize while cleansing/disinfecting the glucose meter to ensure a full 5 minutes elapses prior to next use, as per manufacturer's instructions. 2. All residents requiring blood glucose checks have the potential to be affected. All nurses will be in-serviced on the facility's policy on blood glucose monitoring, infection control practices, and hand washing, (see attachment F). 3. As a measure of ongoing compliance, DON or designee will complete blood sugar monitoring observations, (see attachment H) daily on regularly scheduled days for 30 days, then weekly for 60 days, then monthly ongoing to ensure the facility's policy is followed. Should non-compliance be observed, corrective action/re-education shall be conducted. 4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective actions taken in the facility's quarterly quality assurance meeting. The plan will be revised, accordingly if warranted.</p>				

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	<p>removed gloves and washed her hands. The nurse then placed new gloves and performed the blood sugar testing. While wearing the same gloves used to cleanse the meter after the blood sugar test, the nurse touched the black bag while replacing the meter in the bag. The bag was then placed on the medication cart.</p> <p>Upon review of the manufacturer's recommendation of the Gluco-Chlor wipes used to cleanse the glucometers, received from the DON on 1/15/14 at 9:05 a.m., the documentation indicated, "...Apply towelette and wipe desired surface to be disinfected. Allow treated surfaces to remain wet for 5 minutes. Allow surface to air dry...."</p> <p>On 1/15/14 at 9:45 a.m., The DON indicated the bags for each unit, housing glucometers, lancet and alcohol swabs should not be taken into the individual rooms. Only items needed for the individual resident should have been taken into the room.</p> <p>3.1-18(b)(1)</p>			

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