

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/30/2011
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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 28, 29, and 30, 2011</p> <p>Facility number: 000571 Provider number: 155374 AIM number: 100266920</p> <p>Survey team: Diana Sidell RN, TC Penny Marlatt RN Sharon Whiteman RN (November 28 and 29, 2011)</p> <p>Census type: SNF/NF: 37 Total: 37</p> <p>Census payor type: Medicare: 8 Medicaid: 23 Other: 6 Total: 37</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/06/11 by Suzanne</p>	F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in this Statement of Deficiencies or any violation of regulation. This Plan of Correction is submitted to meet regulations established by state and federal law. We reserve the right to contest the findings or allegations as party to any proceedings. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and respectfully requests a desk review on or after 12/12/2011.</p>	

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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F0282 SS=D	<p>Williams, RN</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 interview and record review, the facility failed to ensure facility staff followed the plan of care in that frequency of bowel movements were not monitored and "as needed" medication was not administered to achieve normal bowel evacuation for 1 of 6 residents reviewed for implementation of the care plan in a total sample of 10. (Resident #25)</p> <p>Findings include:</p> <p>Resident #25's clinical record was reviewed on 11-28-11 at 2:29 p.m. His medical diagnoses included, but were not limited to, traumatic brain injury related to a motor vehicle accident over 20 years ago, right-sided muscle spasticity, right-sided hemiplegia (paralysis), seizure disorder, psychotic mood disorder, anxiety, expressive aphasia and constipation.</p> <p>Review of Resident #25's "Care Plan" indicated a problem identified on 6-25-11 as "Potential for alteration in bowel elimination r/t [related to] med [medication] therapy, decreased mobility, hx [history] of constipation." The short</p>	F0282	F282 Services by Qualified Persons Per Care Plan It is the intent of this facility to have services provided or arranged by the facility to be provided by qualified persons in accordance with each resident's written plan of care. The Corrective Action Taken for Those Residents Found to be Affected by the Deficient Practice: Bowel Movement Record is in place to identify trends and individualize care for resident #25. A bowel assessment was completed by a licensed nurse and resident has had bowel movements consistent with the resident's written plan of care. Resident #25 was reviewed by dietician on 12/12/2011 in regards to constipation. The Corrective Action Taken for Those Residents Having the Potential to be Affected by the Deficient Practice: All residents have the potential to be affected. Bowel Movement Records were reviewed for all residents to identify any affected residents. No other residents were affected. The Measures or Systemic Changes that have been put into Place to Ensure that the Deficient Practice Does Not Recur: To enhance currently compliant operations and under the direction of the Director of	12/12/2011	

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	<p>term goal for this identified problem was indicated as "[Name of Resident #25] will have soft, formed BM Q [every] 1-3 days through next review." The interventions for this identified problem indicated to serve the ordered diet, to encourage fluids, to monitor bowel function, to administer the laxatives as ordered on an as needed basis and monitor their effectiveness, to encourage activity as tolerated and to notify the resident's physician as needed.</p> <p>Review of Resident #25's bowel movement (BM) record for September and October 2011 indicated a lack of any BM from 9-4-11 through 9-9-11 (6 days); from 9-11-11 through 9-15-11 (5 days); from 9-22-11 through 9-26-11 (5 days); from 9-28-11 through 10-5-11 (8 days); 10-10-11 through 10-15-11 (6 days); 10-17-11 through 10-20-11 (4 days) and 10-22-11 through 10-25-11 (4 days).</p> <p>Review of Resident #25's recapitulation orders for November 2011 indicated an order for Colace (a stool softener) 100 milligrams (mg) once daily by mouth and Senna (a laxative) 8.6 mg twice daily by mouth. Each of these orders had a starting date indicated as 6-22-11. Other orders included Dulcolax 10 mg suppository to be inserted into the rectum once daily as needed for constipation and Milk of Magnesia Suspension 30</p>		<p>Nursing Services and/or Designee on 12/10/2011 nursing staff were re-inserviced on the facility's Protocol for Bowel Management and associated tracking forms. A laxative tracking list has been put into place to communicate any resident without a BM per protocol. Day shift nurse will review daily BM records and initiate tracking list for evening shift nurse to administer medications and or treatments as ordered by physician. Results will be documented. Day shift nurse will follow up the next AM to determine need for additional treatment per protocol. The Corrective Action taken to Monitor and Ensure Continuous Compliance through Quality Assurance: On 12/12/11 a QA program was implemented to monitor each resident's individual BM record utilizing a QA tool, "Bowel Elimination." The Director of Nursing and/or Designee will review the BM records of each resident daily Monday through Friday x 30 days, weekly x 4 weeks, monthly x 2 months and quarterly thereafter to ensure facility protocol for Bowel Management is being followed. Results of the QA Audit will be forwarded to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>		

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	<p>milliliters orally once daily as needed for constipation. Each of these "as needed" medications had start dates indicated as 1-16-06.</p> <p>Review of Resident #25's Medication Administration Record (MAR) for September and October 2011 indicated the "as needed" physician's order for Milk of Magnesia was not administered to the resident during this time period. The MAR for the same time period for the "as needed" physician's order for Dulcolax Suppository was administered on 9-15-11, 10-5-11, 10-6-11, 10-17-11, 10-20-11 and 10-29-11.</p> <p>In interview with the Director of Nursing on 11-29-11 at 10:25 a.m., she indicated she could not locate any other documentation other than the above indicated information. She indicated, "They [the nursing staff] must not have documented those things."</p> <p>On 11-30-11 at 2:07 p.m., the DON provided a copy of a policy entitled, "Interventions to Prevent and Manage Constipation," with an activation date of June 2011. This policy indicated, "Bowel management involves promoting regular, voluntary, controlled bowel evacuations of normal consistency...The interdisciplinary team will consider the</p>				

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F0309 SS=D	<p>following before implementing a routine bowel protocol: Documentation on recent bowel records. Assessment for abdominal distension, presence of bowel sounds and nursing assessment. Changes in medications, food or fluid intake, activity level, emotional status. Contributing factors and management of them. Avoid reoccurrence through follow up strategies with the physician or dietician. BM [bowel movement] record is used to identify patterns and trends to individualize care. Assessment is initiated and reviewed by licensed nurse with Bowel Protocol or other physician order. Bowel Protocol may be implemented with a physician order and may include: Milk of Magnesia 30 cc [equal to 2 tablespoons] po [by mouth] Q 3rd day with no BM; Biscodyl suppository, one rectally if no results from Milk of Magnesia; Fleets enema rectally if no results from the biscodyl [sic] suppository."</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident received</p>	F0309	F309 Provide Care and Services for Highest Well Being It is the	12/12/2011

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	<p>necessary care and treatment for constipation, in that frequency of bowel movements were not monitored and "as needed" medication was not administered to achieve normal bowel evacuation, for 1 of 6 residents reviewed for frequency of bowel movements in a total sample of 10. (Resident #25)</p> <p>Findings include:</p> <p>Resident #25's clinical record was reviewed on 11-28-11 at 2:29 p.m. His medical diagnoses included, but were not limited to, traumatic brain injury related to a motor vehicle accident over 20 years ago, right-sided muscle spasticity, right-sided hemiplegia (paralysis), seizure disorder, psychotic mood disorder, anxiety, expressive aphasia and constipation.</p> <p>Review of Resident #25's "Care Plan" indicated a problem identified on 6-25-11 as "Potential for alteration in bowel elimination r/t [related to] med [medication] therapy, decreased mobility, hx [history] of constipation." The short term goal for this identified problem was indicated as "[Name of Resident #25] will have soft, formed BM Q [every] 1-3 days through next review." The interventions for this identified problem indicated to serve the ordered diet, to encourage fluids,</p>		<p>intent of this facility to ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental or psychsocial well-being in accordance with comprehensive assessment and plan of care. The Corrective Action taken for those Residents Found to Be Affected by the Deficient Practice: Bowel Movement record is in place to identify trends and individual care for resident #25. A bowel assessment was completed by a licensed nurse and resident has had bowel movements consistent with his written plan of care. Resident #25 was reviewed by dietician on 12/12/2011 related to constipation. The Corrective Action taken for any other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. BM records were reviewed for all residents to identify any affected residents. No other residents were affected. The Measures or Systemic Changes that have been put into place to ensure that the deficient practice does not recur: To enhance currently compliant operations and under the direction of the Director of Nursing Services and/or Designee on 12/10/2011 nursing staff were re-inserviced on the facility's Bowel Management Protocol and associated tracking</p>		

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	<p>to monitor bowel function, to administer the laxatives as ordered on an as needed basis and monitor their effectiveness, to encourage activity as tolerated and to notify the resident's physician as needed.</p> <p>Review of Resident #25's bowel movement (BM) record for September and October 2011 indicated a lack of any BM from 9-4-11 through 9-9-11 (6 days); from 9-11-11 through 9-15-11 (5 days); from 9-22-11 through 9-26-11 (5 days); from 9-28-11 through 10-5-11 (8 days); 10-10-11 through 10-15-11 (6 days); 10-17-11 through 10-20-11 (4 days) and 10-22-11 through 10-25-11 (4 days).</p> <p>Review of Resident #25's recapitulation orders for November 2011 indicated an order for Colace (a stool softener) 100 milligrams (mg) once daily by mouth and Senna (a laxative) 8.6 mg twice daily by mouth. Each of these orders had a starting date indicated as 6-22-11. Other orders included Dulcolax 10 mg suppository to be inserted into the rectum once daily as needed for constipation and Milk of Magnesia Suspension 30 milliliters orally once daily as needed for constipation. Each of these "as needed" medications had start dates indicated as 1-16-06.</p> <p>Review of Resident #25's Medication</p>		<p>forms. A laxative tracking form has been put into place to communicate any resident without a BM per protocol. Dayshift nurse will review daily BM records and initiate treatment list for evening shift nurse to administer medications and/or treatments as ordered by physician. Results will be documented. Dayshift nurse will follow up the next AM to determine need for additional treatment per protocol. The Corrective Action taken to Monitor and Ensure Continuing Compliance through Quality Assurance: On 12/12/2011 a QA Program was implemented to monitor each resident's individual BM record utilizing QA tool, "Bowel Elimination." The Director of Nursing and/or Designee will review the BM records of each resident daily Monday through Friday x 30 days, weekly x 4 weeks, monthly x 2 months and quarterly thereafter. Results of the QA audit will be forwarded to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>		

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	<p>Administration Record (MAR) for September and October 2011 indicated the "as needed" physician's order for Milk of Magnesia was not administered to the resident during this time period. The MAR for the same time period for the "as needed" physician's order for Dulcolax Suppository was administered on 9-15-11, 10-5-11, 10-6-11, 10-17-11, 10-20-11 and 10-29-11.</p> <p>Review of the "Nurses Notes" for September and October 2011 indicated a lack of documentation in reference to bowel movements or assessments of bowel sounds.</p> <p>In interview with the Director of Nursing on 11-29-11 at 10:25 a.m., she indicated she could not locate any other documentation other than the above indicated information. She indicated, "They [the nursing staff] must not have documented those things."</p> <p>On 11-30-11 at 2:07 p.m., the DON provided a copy of a policy entitled, "Interventions to Prevent and Manage Constipation," with an activation date of June 2011. This policy indicated, "Bowel management involves promoting regular, voluntary, controlled bowel evacuations of normal consistency...The interdisciplinary team will consider the</p>			

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	<p>following before implementing a routine bowel protocol: Documentation on recent bowel records. Assessment for abdominal distension, presence of bowel sounds and nursing assessment. Changes in medications, food or fluid intake, activity level, emotional status. Contributing factors and management of them. Avoid reoccurrence through follow up strategies with the physician or dietician. BM [bowel movement] record is used to identify patterns and trends to individualize care. Assessment is initiated and reviewed by licensed nurse with Bowel Protocol or other physician order. Bowel Protocol may be implemented with a physician order and may include: Milk of Magnesia 30 cc [equal to 2 tablespoons] po [by mouth] Q 3rd day with no BM; Biscodyl suppository, one rectally if no results from Milk of Magnesia; Fleets enema rectally if no results from the biscodyl [sic] suppository."</p> <p>3.1-37(a)</p>				

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F0325 SS=D	<p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure care and monitoring of a resident with an identified significant weight loss in a 30 day time period, for 1 of 5 residents reviewed for weight and/or nutrition related issues in a total sample of 10. (Resident #27)</p> <p>Findings include:</p> <p>Resident #27's clinical record was reviewed on 11-29-11 at 8:47 a.m. Her diagnoses included, but were not limited to, paraplegia secondary to spinal cord injury, atrial fibrillation (irregular heartbeat), high blood pressure, depression, history of deep vein thrombosis and pulmonary emboli (blood clots of the lower extremities and lungs), neurogenic bladder, urinary retention, neuropathy pain and osteoporosis. Her most recent quarterly Minimum Data Set (MDS) assessment, dated 8-25-11, indicated she was cognitively intact. It indicated her height as 64 inches and</p>	F0325	<p>F325 Maintain Nutritional Status Unless Unavoidable It is the intent of this facility, based on a resident's comprehensive assesement, to ensure that a resident 1)maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless resident's clinical condition demonstrates this is not possible; and 2) receives a therpeutic diet when there is a nutritional problem. The Corrective Action Taken for those Residents Found to be Affected by the Deficient Practice: Resident #27 has been placed on weekly weights x 4 weeks. Weight has been stable with no further weight loss through 12/11/2011. Resident was visited by dietician on 12/12/2011 with nutritional assessment and care plan updated to reflect resident's desire to lose weight. Resident has been placed on Nutritional Risk Program for weekly review by Interdisciplinary Team to monitor resident's weight loss goals. Goals were established and added to care plan.</p>	12/12/2011

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	<p>weight as 150 pounds with no chewing or swallowing issues.</p> <p>Review of the nursing notes indicated a "Weight Change Notification" form, dated 11-3-11 at 12:30 (no a.m. or p.m. indicated), which had been faxed to the resident's physician. This form indicated Resident #27's "weight on 11-2 was 141 lbs. This is a 5% weight loss in one months [sic] ...8# loss in 1 month...Res [resident] has been consuming less sweets." Review of the "Resident Weight Record" indicated the most recent weight recorded was on 10-1-11 for a weight of 149 pounds. This 8 pound weight loss would indicate a 5.36% weight loss in a 30 day time period.</p> <p>Review of the "Dietary Progress Note," dated 11-10-11, indicated "Resident wt [weight] is 149# [pounds] (stable)...has good intake at meals...continue to monitor wt...continue current plan of care."</p> <p>In interview with the Director of Nursing (DON) on 11-29-11 at 11:40 a.m., indicated the resident had been re-weighed earlier that morning and had gained one pound, "Up to 142 pounds." She indicated the Dietary Manager was going to write another progress note. She indicated the Dietary Manager had used the October 2011 weight for the note</p>		<p>Interventions will be dated when added. The Corrective Action Taken for any other Residents having the Potential to be Affected by the same Deficient Practice: All resident's weights were reviewed to identify any significant weight gains or losses. No other residents were affected. The Measures or Systemic Changes that have been put into place to ensure that the Deficient Practice Does Not Recur: To enhance currently compliant operations, Skin, Weights and Treatment (SWAT) Interdisciplinary Team Members were re-inserviced on 12/08/2011 to Nutrition at Risk Guidelines and the facility's Policy and Procedure for addressing resident's at nutritional risk. The Corrective Action Taken to Monitor and Ensure Continuing Compliance through Quality Assurance: On 12/12/2011, a QA program was implemented to monitor each resident's weight utilizing QA Tool, "Significant Weight Change." The Director of Nursing Services and/or Designee will complete the audit weekly x 4 weeks, monthly x 2 and quarterly x 2. Results of the QA Audits will be forwarded to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>		

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	<p>written on 11-10-11. She indicated, "I don't know why she hasn't been re-weighed, but I'll make sure she is on weekly weights now." In an interview with the DON on the same date at 1:40 p.m., she indicated she had spoken with the "Skin and Weight Nurse," and that nurse had indicated to her she had not re-weighed the resident since the first part of November. The DON indicated this nurse had indicated to her she had verified the weight at the time, and it was correct, indicating the 8 pound weight loss.</p> <p>Review of another "Dietary Progress Note," dated 11-29-11, indicated, "Dietary Note -- Current wt is 142# / wt in Oct was 149# -- 5% of 149# is 7.45#. This is not quite 5%, but due to the 8# loss, we will put her on weekly weights -- Dr was notified of wt loss."</p> <p>Review of the "Dietary Care Plan" with a date of 3-16-11, indicated an identified problem as "Oct. [October] wt shows an 8# wt loss." This problem did not indicate any date other than the above listed "3-16-11." This problem had no goal listed. An intervention indicated for this problem was, "Weekly weights." This intervention did not indicate a date to specify if this was related to this particular problem or other dietary related issues on the care plan; however, these were the last</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
(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>items listed on the care plan.</p> <p>On 11-30-11 at 9:42 a.m., the DON provided a copy of a policy entitled, "Identifying Residents at Nutritional Risk," with an effective date of 11-10-10. This policy indicated, "Residents who are identified at nutritional risk are placed on the nutrition risk program, which consists of weekly weights (or more frequently if indicated), daily mealtime monitoring, and evaluation for between meal nourishments (snacks and/or supplements). The resident's plan of care is monitored weekly (or as otherwise specified) by the interdisciplinary care team. The Nutrition Tracking Form, Food Intake Record, Weight Log Form, and Wound Care Tracking are used to help identify residents at nutritional risk...Residents with any of the following conditions are considered at nutritional risk...Weight changes of 5% in 30 days...When a resident is identified at nutritional risk , the following procedure takes place:...Weekly or more frequent resident weights are recorded in the Weight Log Book by the nursing staff..."</p> <p>3.1-46(a)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553			
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F0387 SS=E	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure physician visits were conducted timely in that residents did not have physician visits every 30 days for the first 90 days after admission, and then every 60 days. This affected 4 of 9 residents reviewed for timely physician visits in a sample of 10. (Residents #14, 23, 6, and 25)</p> <p>Findings include:</p> <p>A policy and procedure for "Physician Visits", with a review date of 8/2011, was provided by the Director of Nurses on 11/30/11 at 3:06 p.m. The policy indicated: "Policy Statement: It is the policy of this facility that residents be seen by their attending physician at least every ninety (90) days. Procedure: 1. The resident must be seen by his/her attending physician at least once every thirty (30) days for the first ninety (90) days following the resident's admission. 2. The resident's total program of care (including medication and treatments) must be reviewed at least every thirty (30)</p>	F0387	<p>F387 Frequency and Timeliness of Physician Visits It is the intent of this facility for each resident to be seen by the physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A physician visit is considered timely if the visit occurs not later than ten days after the date the visit was required. At the option of the physician, a nurse practitioner may make alternate visits after the initial visit as allowed by regulation. The Corrective Action Taken for those Resident's Found to be Affected by the Deficient Practice: Residents 14, 23, 6 and 25 have been seen by a physician. Their medications and treatments were reviewed by the Physician and appropriate medical interventions were ordered as the physician deemed necessary. The Corrective Action Taken for any Other Residents Having the Potential to be Affected by the Same Deficient Practice: All resident's medical records were audited for timely physician visits by the Quality Assurance Nurse/Medical Records Designee. All residents have</p>	12/12/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
(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>days for the first ninety (90) days, and revised as necessary. 3. Once the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established. 4. The resident's attending physician must review the resident's total program of care, including medications and treatments, at least quarterly. 5. A physician visit is considered timely if it occurs not later than ten (10) days after the date the visit was required. 6. A physician assistant or nurse practitioner may make alternate visits after the initial visit, unless restricted by law or regulation."</p> <p>1. Resident #14's record was reviewed on 11/29/11 at 10:05 a.m. The record indicated Resident #14 was admitted with diagnoses that included, but were not limited to, severe iron deficiency, dementia, congestive heart failure, depression, renal insufficiency, diabetes type 2, and peripheral neuropathy.</p> <p>Physician's progress notes indicated the physician visited on 5/25/11 then made no further visits until 9/27/11, for a lapse of four months.</p> <p>During an interview on 11/30/11 at 4:28 p.m., the Director of Nurses indicated she</p>		<p>been seen by physician within the parameters of the regulation. The Measures or Systemic Changes that have been put into place to ensure that the deficient practice does not recur: To enhance currently compliant operations, the Quality Assurance Nurse/Medical Records Designee was re-inserviced to updated policy and procedure on Physician Visits on 12/09/2011. A letter including regulations for timely physician visits was hand delivered to one attending physician and Medical Director on 12/02/2011. The Quality Assurance Nurse/Medical Records Designee maintains a calendar of visits and faxes a list of residents with upcoming physician visits required to each physician office weekly. The Quality Assurance Nurse/Medical Records Designee will also place a phone call to the physician's office as a reminder if visits. The Quality Assurance Nurse/Medical Records Designee will track timely physician visits and will notify Administrator of any visits not held by the date indicated. The Administrator will contact the physician and/or Medical Director to ensure timely visit. The Corrective Measures Taken to Monitor and Ensure Continuing Compliance through Quality Assurance: On 12/12/2011, a QA program was implemented to monitor each resident's physician visits utilizing</p>		

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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
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	<p>was not aware the policy didn't match the state and federal regulations.</p> <p>2. Resident #23's record was reviewed on 11/28/11 at 2:33 p.m. The record indicated Resident #23 was admitted with diagnoses that included, but were not limited to, closed head trauma with behavior disorder, seizure disorder, left sided weakness, right sided paralysis, and difficulty swallowing.</p> <p>Physician's progress notes indicated the physician visited on 3/28/11 then made no further visits until 9/12/11, for a lapse of five and half months.</p> <p>On 11/30/11 at 4:36 p.m., the Quality Assurance/Medical Records director indicated she could not find any other physician's progress notes for Resident #14 or 23.</p> <p>3. Resident #6's clinical record was reviewed on 11-30-11 at 8:48 a.m. Her diagnoses included, but were not limited to, profound mental retardation, Down's Syndrome, seizure disorder, dementia, anemia, hypothyroidism, constipation, chronic blepharitis, seasonal allergies and weight loss.</p> <p>Review of Resident #6's visits from her primary care physician indicated he had conducted a visit most recently on</p>		<p>a QA tool, "Physician Services." The Quality Assurance Nurse/Medical Records Designee will review physician visits weekly and in conjunction with scheduled visits to ensure each resident receives visit every 30 days for the first 90 days following admission and every 60 days after the first 90 days. Results of the QA Audit will be forwarded to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
(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>5-25-11. The next medical visit after this date was conducted by a nurse practitioner on 9-27-11. This indicates a lapse of medical visits from 5-25-11 until 9-27-11, for a period of 4 months.</p> <p>4. Resident #25's clinical record was reviewed on 11-28-11 at 2:29 p.m. His medical diagnoses included, but were not limited to traumatic brain injury related to a motor vehicle accident over 20 years ago, right-sided muscle spasticity, right-sided hemiplegia (paralysis), seizure disorder, psychotic mood disorder, anxiety, expressive aphasia and constipation.</p> <p>Review of Resident #25's visits from his primary care physician indicated he had conducted a visit most recently on 5-29-11. The next medical visit after this date was conducted by a nurse practitioner on 9-20-11. This indicates a lapse of medical visits from 5-29-11 until 9-20-11, for a period of 16 weeks, almost 4 months.</p> <p>3.1-22(d)(1) 3.1-22(d)(2) 3.1-22(d)(3) 3.1-22(d)(4)</p>				

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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553
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F0441 SS=E	<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. Based on observation, interview, and record review, the facility failed to ensure a blood glucose meter was disinfected between resident use, to help prevent the development and transmission of disease</p>	F0441	F441 Infection Control, Prevent Spreak, Linens It is the intent of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable	12/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553			
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	<p>and infection, for 2 residents observed (#29 and #37) during 1 of 2 observations and 1 of 2 glucose meters. This deficient practice had the potential to affect 4 residents who received routine glucose monitoring on the skilled hall.</p> <p>Findings include:</p> <p>On 11/29/11 at 10:55 a.m., LPN #7 was observed using a blood glucose meter on resident #29. After the blood glucose meter was used, LPN #7 placed the glucose meter in a drawer in the med cart without sanitizing the meter.</p> <p>On 11/29/11 at 11:12 a.m., LPN #7 was observed as she retrieved the same glucose meter from the med cart and used the meter on Resident #37. LPN #7 was not observed cleaning the meter after its use on Resident #29 nor prior to use on Resident #37.</p> <p>On 11/29/11 at 11: 18 a.m., LPN #7 indicated she didn't clean the meter between the two residents. She said she would use an alcohol wipe to clean the machine and took out an alcohol wipe and wiped off the meter. She said they also "have sani-wipes to wipe the meter down."</p> <p>Manufacturer's guidelines for cleaning</p>		<p>environment and to help prevent the development and transmission of disease and infection. The Corrective Action taken for those residents found to be affected by the deficient practice: No resident's were affected by this cited deficiency. LPN #7 has been provided with one on one instruction on the Policy and Procedure related to cleaning and disinfecting of the glucometer. The corrective action taken for those residents having the potential to be affected by this deficient practice: All resident's have the potential to be affected. No residents were affected. LPN # 7 has been provided with one on one instruction on the Policy and Procedure related to cleaning and disinfecting of the glucometer. The Measures or Systemic Changes that have been put into place to ensure that the deifcent practicde does not recur: To enhance currently compliant operations and under the direction of the Director of Nursing Services. all nurses were re-inserviced on the facility's policy and procedure for cleaning the Blood Glucose Meter on 12/10/2011. Nurse's completed a skill competency check-off which included cleaning and disinfecting the Blood Glucose Meter. On 12/12/2011, a QA Program was implemented to monitor the cleaning and disinfecting of the Blood Glucose Meter utilizing QA</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
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	<p>and disinfecting the glucose meter were provided by the MDS Coordinator on 11/30/11 at 2:31 p.m. The guidelines indicated "...Cleaning: Healthcare professionals should wear gloves when cleaning the Assure 4 meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the meter between patients...To disinfect the meter, dilute 1 mL (milliliter) of household bleach (5% -6% sodium hypochlorite solution) in 9 mL of water to achieve a 1:10 dilution (final concentration of 0.5%-0.6% sodium hypochlorite)....."</p> <p>A policy for "Cleaning and Disinfecting Blood Glucose Meters", with a review date of 12/2010, was provided by the Administrator on 11/30/11 at 9:42 a.m. The policy included, but was not limited to: "Due to CMS's most current guideline on Infection Control (Tag F441), it is our policy to clean and disinfect blood glucose meters between each resident test to avoid cross contamination issues. Our policy is as follows: 1. Clean with an approved germicidal cleanser. 2. Wash hands. 3. Clean glucose meter before and after each resident use...."</p> <p>During the daily meeting on 11/29/11 at 5:50 p.m., the Director of Nurses indicated they have the sani-wipes for use</p>		<p>tool, "Infection Control- Blood Glucose Meter." The Director of Nursing Services and/or Designee will randomly watch infection control procedures of the glucometer during insulin injections daily x 5 days, weekly x 4 weeks, monthly x 2 months and quarterly x 2. Results of the QA Audit will be forwarded to the Quality Assurance Committee Quarterly to ensure continuing compliance or additional action as warranted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/30/2011
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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553
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(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
F0514 SS=D	<p>on the glucose meter between residents.</p> <p>3.1-18(b)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was congruent in regard to a resident with an identified 5% weight loss in a 30 day time period (Resident #27) and documentation was present for the food consumption record of a newly admitted resident who had nutritional supplementation added for concerns related to poor intake (Resident #32). These deficient practices affected 2 of 10 residents reviewed for completeness of clinical records in total sample of 10.</p> <p>Findings include:</p> <p>1. Resident #27's clinical record was reviewed on 11-29-11 at 8:47 a.m. Her diagnoses included, but were not limited to, paraplegia secondary to spinal cord</p>	F0514	<p>F514 Resident Records-Complete, Accurate and Accessible It is the intent of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. The corrective action taken for those resident's found to be affected by the deficient practice: Resident #27 has been placed on weekly weights x 4 weeks. Weight has been stable with no further weight loss through 12.11/2011. Resident has been visited by dietician on 12/12/2011 with nutritional assessment and care plan updated to reflect resident's desire to lose weight. Resident has been placed on Nutritional Risk Program for weekly review by Interdisciplinary</p>	12/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553		
(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>injury, atrial fibrillation (irregular heartbeat), high blood pressure, depression, history of deep vein thrombosis and pulmonary emboli (blood clots of the lower extremities and lungs), neurogenic bladder, urinary retention, neuropathy pain and osteoporosis. Her most recent quarterly Minimum Data Set (MDS) assessment, dated 8-25-11, indicated she was cognitively intact. It indicated her height as 64 inches and weight as 150 pounds with no chewing or swallowing issues.</p> <p>Review of the nursing notes indicated a "Weight Change Notification" form, dated 11-3-11 at 12:30 (no a.m. or p.m. indicated), which had been faxed to the resident's physician. This form indicated Resident #27's "weight on 11-2 was 141 lbs. This is a 5% weight loss in one months [sic] ...8# loss in 1 month...Res [resident] has been consuming less sweets." Review of the "Resident Weight Record" indicated the most recent weight recorded was on 10-1-11 for a weight of 149 pounds. This 8 pound weight loss would indicate a 5.36% weight loss in a 30 day time period.</p> <p>Review of the "Dietary Progress Note," dated 11-10-11, indicated "Resident wt [weight] is 149# [pounds] (stable)...has good intake at meals...continue to monitor</p>		<p>Team to monitor resident's weight loss goals. Resident #32 is on weekly weights as new admission to the facility. Intake is monitored and recorded at each meal. Resident.s weight and nutritional status are reviewed weekly by Interdisciplinary Team during Skin, Weight and Treatment (SWAT) meeting. Resident status has been reviewed by dietician Care plans are current to address resident's nutritional status. The corrective action taken for any other residents having the potential to be affected by the same deficient practice: A housewide audit of weights and meal consumption records was completed. Nursing Staff were re-inserviced on daily documentation of meal consumptions on the meal consumption log following each meal. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: To enhance currently compliant operations and under the direction of the Dietary Services Manager meal consumption logs are brought to the AM Department Manager's Meeting, Monday through Friday to ensure they are completed daily Weights are obtained weekly or monthly on each resident and are reviewed by the Interdisciplinary Team at the Skin, Weight and Treatment (SWAT) Meeting for appropriate interventions. The</p>		

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NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN47553			
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	<p>wt...continue current plan of care."</p> <p>In interview with the Director of Nursing (DON) on 11-29-11 at 11:40 a.m., indicated the resident had been re-weighed earlier that morning and had gained one pound, "Up to 142 pounds." She indicated the Dietary Manager was going to write another progress note. She indicated the Dietary Manager had used the October 2011 weight for the note written on 11-10-11. In an interview with the DON on the same date at 1:40 p.m., she indicated she had spoken with the "Skin and Weight Nurse," and that nurse had indicated to her she had not re-weighed the resident since the first part of November. The DON indicated this nurse had indicated to her she had verified the weight at the time, and it was correct, indicating the 8 pound weight loss.</p> <p>Review of another "Dietary Progress Note," dated 11-29-11, indicated, "Dietary Note -- Current wt is 142# / wt in Oct was 149# -- 5% of 149# is 7.45#. This is not quite 5%, but due to the 8# loss, we will put her on weekly weights -- Dr was notified of wt loss."</p> <p>Review of the "Dietary Care Plan" with a date of 3-16-11, indicated an identified problem as "Oct. [October] wt shows an 8# wt loss." This problem did not</p>		<p>corrective action taken to monitor and ensure continuing compliaince through Quality Assurance: On 12/12/2011, a QA Program was implemented to monitor each resident's weight and documented meal intake utilizing QA tool, "Weight Loss" The Food Services Manager and/or Designee will review the meal consumption records daily Monday through Friday. The Director of Nursing Services and/or Designee will complete the audit tool weekly x 4, monthly x 2 and quarterly x 2. Results of the QA Audit will be forwarded to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/30/2011
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(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>indicate any date other than the above listed "3-16-11." This problem had no goal listed. An intervention indicated for this problem was, "Weekly weights." This intervention did not indicate a date to specify if this was related to this particular problem or other dietary related issues on the care plan; however, these were the last items listed on the care plan.</p> <p>2. Resident #32's clinical record was reviewed on 11-29-11 at 4:42 p.m. His diagnoses included, but were not limited to, left upper lobe cancer with surgical resection in 2011; acute toxic metabolic encephalopathy secondary to carcinomatosis meningitis (Nov. 2011), chronic obstructive pulmonary disease, peripheral vascular disease and peripheral arterial disease. The clinical record indicated he was newly admitted to the facility on 11-25-11.</p> <p>Review of the nurse's notes from admission through 11-29-11 indicated multiple indications of "fair" to "poor" oral intake. His weight upon admission was indicated as 137 pounds, on 11-26-11 as 134 pounds and on 11-27-11 138 pounds. There was not a height indicated for this resident. Review of the "Dietary Monitor" form only indicated meal consumption documentation for the breakfast meal on 11-26-11, 11-27-11,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011
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F9999	<p>11-28-11 and 11-29-11. An indication of "LOA" (leave of absence) was indicated for the lunch meal on 11-29-11. The lunch consumption documentation for 11-26-11, 11-27-11 and 11-28-11 was absent. The supper consumption documentation for 11-26-11, 11-27-11, 11-28-11 and 11-29-11 was absent.</p> <p>On 11-30-11 at 9:42 a.m., the DON provided a copy of a policy entitled, "Identifying Residents at Nutritional Risk," with an effective date of 11-10-10. This policy indicated, "...Food intake is recorded for each resident..."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> <p><b>3.1-14 PERSONNEL</b></p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.</p> <p>This state rule was not met as evidenced by:</p>	F9999	F9999 Personnel It is the intent of this facility to require a physical examination for each employee of the facility within one month prior to employment. The corrective action taken for those residents found to be affected by the deficient practice: No residents were affected. CNA #2 obtained updated employee physical on 12/09/2011. All employee files were audited by Administrative Assistant and no other employees	12/12/2011	

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	<p>Based on interview and record review, the facility failed to ensure timely pre-employment physical examinations for 1 of 6 employees reviewed for pre-employment requirements. (CNA #2)</p> <p>Findings include:</p> <p>CNA #2's employee file was reviewed on 11-30-11 at 10:35 a.m. Her physical examination was indicated to have been conducted on 6-22-11, and her employment start date was indicated as 9-14-11. This indicated the physical examination occurred 12 weeks or approximately 3 months prior to employment.</p> <p>In interview with the Director of Nursing on 11-30-11 at 3:30 p.m., she indicated she could not locate any other physical examination for this employee.</p> <p>On 11-30-11 at 4:26 p.m., the Director of Nursing provided a policy entitled, "Employee Physicals," with a review date of August 2011. This policy indicated, "It is the policy of the facility for each employee to have a physical within one month prior to employment."</p> <p>3.1-14(t)</p>		<p>were affected. The corrective action taken for any other residents having the potential to be affected by the same deficient practice: No other employees were affected. The Administrative Assistant audited all employee files for compliance. All employees have physical examination within one month prior to employment. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: To enhance currently compliant operations, the Administrative Assistant was re-inserviced to the Policy and Procedure for new hires including the need for each employee to have an employee physical no more than one month prior to employment. The Administrative Assistant schedules an employee physical for all newly hired employees. . The Corrective Action taken to monitor and ensure continuing compliance through Quality Assurance: On 12/12/2011 a QA Program was implemented to monitor employee physicals utilizing a QA tool, "Employee Records," This tool will be completed by the Administrator or Designee with each new hire for the next 90 days and monthly thereafter. Results of this audit will be provided to the QA Committee quarterly to ensure continuing compliance or additional action as warranted.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2011

FORM APPROVED

OMB NO. 0938-0391

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