

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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.</p> <p>Survey Dates: May 8, 9, 12, 13 &amp; 14, 2014</p> <p>Facility number: 000423 Provider number: 155704 AIM number: 100290450</p> <p>Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN May 8, 9, 12 &amp; 14, 2014. Karina Gates, Generalist Tom Stauss, RN</p> <p>Census Bed Type: SNF: 5 SNF/NF: 50 Total: 55</p> <p>Census Payor Type: Medicare: 11 Medicaid: 37 Other: 7 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 16,</p>	F000000	<p>This Plan of Correction is the facility's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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
F000280 SS=D	<p>2014 by Cheryl Fielden, RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182			
(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>representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise a mood/behavior care plan, nutrition care plan, and a dental care plan for 3 of 28 residents reviewed for care plans (Resident #38, #81, #69).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #38 was reviewed 5/13/14 at 1:45 p.m. The diagnoses for Resident #38 included, but were not limited to, Alzheimer's, depression, and osteoarthritis.</p> <p>A Physician's Order, dated 1/22/13, indicated an order for depakote (mood stabilizer medication) 250 mg (milligrams) by mouth twice daily.</p> <p>A Consultation Report from a pharmacist, dated 3/3/14, indicated a recommendation for monitoring valporic acid serum concentration (lab for depakote level) to monitor efficacy and toxicity of depakote medication levels.</p> <p>A Physician's Order, dated 3/19/14, indicated an order for a depakote level lab (valporic acid serum concentration) and then yearly, thereafter.</p>	F000280	<p>Comprehensive Care Plans for resident #38 and resident #69 have been reviewed and revised by the Interdisciplinary Team including inviting the resident and family. Resident #81 met his goals for short term rehabilitation and was discharged from the facility to his home on 5/15/14. Residents with laboratory orders, who receive dialysis or who have dental problems have the potential to be affected by the practice. Those potentially affected residents have had their Care Plans reviewed and revised as necessary. Nursing staff and Interdisciplinary team members have been reeducated on Care Plan revision. Director of Nursing or designee will audit the Interdisciplinary Care Plan process ensuring that each resident has a comprehensive care plan, revised to meet their needs. Director of Nursing will audit 5 care plans weekly times four weeks then 5 care plans monthly for a period of not less than 9 months and report progress to the Quality Assessment and Assurance Committee for subsequent plan revision.</p> <p>Care Plan Audit Resident NameDateUnitIDT dateAuditor Initials</p>	06/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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
F000322 SS=D	<p>A review of the Mood/Behavior Care Plans for Resident #38 did not indicate an intervention of labs, as ordered.</p> <p>During an interview with the Social Services Director (SSD), on 5/12/14 at 2:19 p.m., she indicated she was unable to locate an intervention for the valporic acid serum concentration lab on any of the Care Plans related to depakote use, for Resident #38. The SSD also indicated she was in charge of creating/revising care plans related to mood stabilizer medication use.</p> <p>On 5/12/14, at 2:25 p.m., the Director of Nursing indicated the order for a valporic acid serum concentration lab should be on a Depakote/Mood/Behavior Care Plan for Resident #38.</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182		
(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>treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a gastrostomy tube received tube feedings as ordered by the physician. This affected 1 of 4 residents with a gastrostomy tube. (Resident #108)</p> <p>Findings include:</p> <p>Resident #108's record was reviewed on 5/9/14 at 11:12 am. The resident's diagnoses included, but were not limited to, history of STEMI with CVA ( heart attack, abrupt change in mental status, history of lung cancer, bladder cancer, depression, hallucinations, seizure, and dysarthria.</p> <p>Resident #108's record indicated the following weights: 2/16/14 195 lbs., 3/3/14 194 lbs., 4/15/14 192 lbs., 4/17/14 178 lbs., 4/24/14 175 lbs., 4/29/14 172 lbs., 5/6/14 166 lbs., and 5/12/14 164 lbs.</p> <p>On 5/12/14 at 10:56 a.m., the Wound Nurse indicated Resident #108 refused lunch "all last week" and indicated he receives tube feeding supplementation</p>	F000322	<p>Resident #108 has been assessed by the Registered Dietitian and his primary care physician. His gastrostomy feeding orders have been verified by them. Residents with gastrostomy feedings returning from the hospital have the potential to be affected by this practice. Nurses have been reeducated on processing resident orders upon return from acute care hospitals. A second nurse will independently verify the accuracy of the orders before administration of medications, treatments or diets. The Director of Nursing or designee will review the orders of residents returning from the hospital weekly for 4 weeks then 4 residents monthly for a period of not less than 9 months and report progress to the Quality Assessment and Assurance Committee for subsequent plan revision.</p> <p>New/Return Admission Orders Audit Resident NameDateUnitNurse 1Nurse 2Correct Y/NAuditor Initials</p>	06/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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>when he eats less than 50 % of meals.</p> <p>On 5/12/14 at 10:58 a.m., the Dietary Manager indicated Resident #108 "refuses a lot of meals."</p> <p>A progress note completed by the RD on 4/21/14 indicated Resident #108's weight was "down 14.9 lbs" between 4/17 and 4/21/14. The note recommended Resident #108 should receive QID (four times daily) tube feedings of Jevity 1.2 to provide additional caloric intake.</p> <p>A physician's order, dated 4/30/14, indicated the resident should receive tube feedings of Jevity 1.2 per the gastrostomy tube at 12 a.m., 9 a.m., 3 p.m., and 8 p.m.</p> <p>The tube feedings for May 6 through May 11, 2014 at 9:00 p.m., were not given.</p> <p>A care plan, updated 4/30/14 indicated the following: "...Has g tube..." (gastrostomy tube) and included the following intervention: "...Jevity 1.2 g tube 240 cc Bolus (bulk amount) if eats &lt; (less than) 50%..."</p> <p>Another care plan, dated 5/5/14 indicated the following problem for Resident #108: "...weight loss..." and included the following intervention: "...Jevity 1.2 240 ml (milliliter) bolus if eats &lt; 50% of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182			
(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>meals..."</p> <p>On 5/12/14 at 12:08 p.m., the DON indicated Resident #108 was readmitted to the facility, on or around 5/5/14, after a short stay in the hospital. She indicated the hospital discharge orders indicated to resume scheduled bolus tube feedings which were ordered four times a day regardless of what Resident #108 would eat by mouth. She indicated the order to resume scheduled (4 times daily) tube feedings did not get updated in the resident's order set. She indicated, as a result, Resident #108 did not receive some scheduled tube feedings as ordered by the physician.</p> <p>A physician's order, dated 5/5/14, indicated "...Resume previous bolus g-tube (gastrostomy tube) feeding..."</p> <p>On 5/13/14 at 11:47 a.m., the Registered Dietitian (RD) indicated she recommended increasing the tube feeding supplementation from an as needed status to a scheduled daily status due a "significant weight loss" for Resident #108. She also indicated not receiving the tube feedings as ordered by the MD may have partially contributed to Resident #108's weight loss.</p> <p>3.1-44(a)(2)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <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 a resident's nutritional status was assessed by a Registered Dietician (RD) as recommended, for 1 of 4 residents reviewed for nutrition. (Resident #81)</p> <p>Findings include:</p> <p>Resident #81's clinical record was reviewed on 5/14/2014 at 11:30 a.m. Resident #81's diagnoses included but were not limited to; acute renal failure, chronic renal failure, and end stage renal disease: on dialysis, diabetes.</p> <p>MD orders indicated, "4/8/2014: regular reduced concentrated sweets. 4/16/2014: increase protein in diet 3-4 times daily."</p> <p>A care plan, dated 4/14/2014, indicated, "Focus: Altered nutrition and</p>	F000325	<p>Resident #81 met his goals for short term rehabilitation and was discharged from the facility to his home on 5/15/14. Residents receiving dialysis have the potential to be affected by the alleged deficient practice. Currently there are no residents receiving dialysis. The Dietary Manager reeducated on the process for making a referral to the Registered Dietician. The Registered Dietician will include a copy of the RD referral form with the RD report for each visit. Administrator or designee will audit the Registered Dietician reports and notes for 10 residents monthly times for a period of not less than 9 months and report progress to the Quality Assessment and Assurance Committee for subsequent plan revision.</p> <p>Dietician Referral Audit ResidentDateUnitReferred by?RD Note Y/N?Correct Y/N?Auditor</p>	06/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182			
(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>hydration...Interventions: RD evaluation as needed."</p> <p>An initial nutrition assessment, signed by the DM (Dietary Manager), on 4/14/2014 at 8:24 a.m., indicated, "Will recommend RD review due to dialysis treatment."</p> <p>An interview with the DM, on 5/14/2014 at 12:10 p.m., indicated, "The dietician should have reviewed him. The dietician reviews all residents for an initial assessment approximately 5 days after they are admitted. I'm not sure why the dietician didn't assess this resident, I recommended he was needing to be reviewed."</p> <p>A telephone interview with the RD (Registered Dietician), on 5/14/2014 at 12:40 p.m., indicated she would review the residents who the DM had filled out a sheet for. "The DM specifically gives me a form, called the RD alert sheet, for each resident who needs to be reviewed. I did not review Resident #81, because I can't find any notes on him, and if I had reviewed him I would have notes about it. The DM must have not filled out a RD alert sheet. I do not routinely review all residents after they are admitted."</p> <p>A DM progress note, dated 5/14/2014 at</p>		Initials				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182		
(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	
F000329 SS=D	<p>12:04 p.m., indicated, "RD recommends a CMP (comprehensive metabolic panel blood draw test) to be completed..."</p> <p>3.1-46(a)(1)</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 attempt/discuss a second Gradual Dose Reduction (GDR) within the first year of a mood stabilizer</p>	F000329	Resident #38 assessed by her primary care provider and a gradual dose reduction was determined to be clinically contraindicated at this time by the	06/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182			
(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>medication initiation for 1 of 5 residents reviewed for unnecessary medication use. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed 5/13/14 at 1:45 p.m. The diagnoses for Resident #38 included, but were not limited to, Alzheimer's, depression, and osteoarthritis.</p> <p>A Physician's Order, dated 1/22/13, indicated an order for depakote (mood stabilizer medication) 250 mg (milligrams) by mouth twice daily.</p> <p>A pharmacy Consultation Report, dated 10/7/13, indicated a contraindication for a GDR for depakote. Resident #38's Physician signed the document.</p> <p>No other GDR or contraindication for a GDR for depakote was located in the clinical record</p> <p>During an interview with the Director of Nursing (DoN), on 5/14/14 at 9:25 a.m., she indicated she was unable to locate documentation that indicated a GDR or contraindication for a GDR of depakote was discussed a second time during the first year of the medication initiation. The DoN further indicated a second GDR</p>		<p>provider. Residents receiving psychoactive medications have the potential to be at risk for the alleged deficient practice. Interdisciplinary team members reeducated on Gradual Dose Reduction procedures. The Behavior Management team will add a second nurse to expand the information available, improve follow up and documentation of meeting minutes. The Social Services Director will report the status of residents' Gradual Dose Reductions to the Quality Assessment and Assurance Committee monthly for a period of not less than 9 months and report progress to the Quality Assessment and Assurance Committee for subsequent plan revision.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182		
(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=D	<p>attempt/discussion should have taken place for the medication.</p> <p>3.1-48(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who 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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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>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 prevent medications, prepared in advance for multiple residents, from being left in a medication cart open to air and unlabeled. This had the potential to affect 2 out of 6 residents who received medications from the medication cart. (Resident's #117 &amp; #118)</p> <p>Findings include:</p> <p>On 5/14/14 at 10:28 a.m., during a medication cart storage observation in a Rehab unit medication cart, four medication portion cups (2 unlabeled cups of pills and 2 unlabeled cups of liquids) were observed on the top shelf of a locked medication cart containing medications for Resident's #117 and #118 and other rehabilitation unit residents. No staff were working on or near the cart at the time. Of the two medication cups filled with fluids, one was a blue liquid and the other a pink liquid. Of the two medication cups containing pills, one cup contained 4 pills and the other contained 10 pills. The Wound Nurse, who identified herself as a nursing staff supervisor who periodically would audit the medication pass procedures by</p>	F000431	<p>Residents #117 and #118 did not receive the medications in discussion. All residents have the potential to be affected by the alleged deficient practices. Qualified Medication Assistant #1 reeducated on safe Medication Administration practices. QMAs will be tested semiannually and must show competence to continue administering medications. Director of Nursing or designee will check medication carts for unlabeled or open medications weekly for 4 weeks then monthly for a period of not less than 9 months and report progress to the Quality Assessment and Assurance Committee for subsequent plan revision.</p> <p>Medication Cart Safety Measures Audit</p> <p>Medication CartDateUnitCorrect Y/NStaff InitialsDisciplinary Action Y/NAuditor Initials</p>	06/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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>licensed staff, was present during the medication cart observation. The QMA passing medication from the cart indicated the residents who were to receive the unlabeled medications were Resident's #117 and #118. QMA #1 identified the 4 pills in the cup indicated for Resident #118 as "fish oil, aspirin, Imdur, and Losartan", but could not identify all 10 of the pills in the cup which she indicated was for Resident #117. The medication cups with liquid medications in them were identified by QMA #1 as for Resident #117. The medication cart was one of two medication carts on the rehab unit and contained medications for six rehab unit residents. At 10:36 a.m., as QMA #1 was counting the pills in the unlabeled medication cups, she was observed touching the pills with the fingers of her right hand.</p> <p>On 5/14/14 at 10:47 a.m., the Wound Nurse indicated QMA #1 should not have left unlabeled medications open in the medication cart for later distribution to facility residents. She indicated the practice is against facility policy.</p> <p>On 5/14/14 at 10:57 am, during an interview, the DON indicated licensed staff should not place unlabeled medications in an unlabeled medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
---	---

(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>cup in a medication cart, locked or unlocked. She indicated doing so could lead to a medication error.</p> <p>On 5/14/14 at 11:58 a.m., the Wound Nurse indicated QMA #1 should not have touched the medications with her bare hands as facility policy indicated otherwise.</p> <p>A facility policy titled "...General Dose Preparation and Medication Administration..." indicated the following: "...Facility staff should only prepare medications for one resident at a time..." and "...Facility staff should not touch the medication..."</p> <p>3.1-25(m) 3.1-25(n)</p>			