

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/04/2014
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NAME OF PROVIDER OR SUPPLIER  ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00139713, IN00140958 &amp; IN00142280.</p> <p>Complaint IN00139713 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00140958 Unsubstantiated due to lack of evidence</p> <p>Complaint IN00142280 Substantiated. Deficiencies related to the allegations are cited at F9999.</p> <p>Survey dates: January 26, 27, 28, 29, 30, 31, February 1, 2, 3 &amp; 4, 2014</p> <p>Facility number: 000135 Provider number: 155230 AIM number: 100266820</p> <p>Survey team: Leslie Parrett RN TC Angel Tomlinson RN ( January 26, 27, 28, 29, 30, 31, February 1, 2 &amp; 4, 2014) Penny Marlatt RN (January 26 &amp; 27, 2014)</p>	F000000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</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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	<p>Barbara Gray RN</p> <p>Census bed type: SNF: 9 SNF/NF: 79 Total: 88</p> <p>Census payor type: Medicare: 17 Medicaid: 48 Other: 23 Total: 88</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on February 11, 2014.</p>						
F000247 SS=D	<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 interview and record review the facility failed to notify a resident that a new roommate was being moved into her bedroom for 1 of 5 residents reviewed for</p>	F000247	F247 Right to Notice Before Room/Roommate Change; It is the practice of Rosebud Village to ensure that the residents receive notice before room/roommate change. What corrective action	02/24/2014			

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	<p>notification of 2 who met the criteria for admission, transfer and discharge (Resident #71).</p> <p>Finding include:</p> <p>During an interview with Resident #71 on 1-28-14 at 9:29 a.m., she indicated had a roommate change in the last nine months. Resident #71 indicated she had not been notified by the facility before the roommate moved in.</p> <p>Review of the record of Resident #71 on 2-4-14 at 8:30 a.m., indicated the resident's diagnoses included, but were not limited to, femur fracture, hypertension, Alzheimer's disease and depression.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment dated 12-16-13 for Resident #71 indicated the resident's BIMS (Brief Interview for Mental Status) was a 9-moderately impaired.</p> <p>During an interview with the Director Of Nursing (DON) on 2-4-14 at 11:10 a.m., she indicated there was no documentation of Resident #71 being notified of getting a new roommate. The DON indicated Resident #71 received a new</p>		<p>will take place for those residents found to be affected by the deficient practice? Resident #71 does not have concerns with her roommate. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected. Social Services Director will ensure that all residents will have notice before room/roommate change. DNS/Designee conducted a chart audit to ensure residents receiving a new roommate were notified, within the last month. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided Nurses and Memory Care Facilitator in-service on Intra-Facility Transfers policy. Social Services Director/Designee will be in-serviced upon hire 2/28/14 to ensure Intra-Facility Transfer completed on all residents prior to all room/roommate changes. DNS/Designee will review documentation to ensure room/roommate change was documented in the resident medical record. How will the corrective actions be monitored to ensure they do not occur again? An Intra-Facility Transfers CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly</p>				

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	<p>roommate on 11-6-13.</p> <p>The "Intra-Facility Transfers" policy provided by the DON on 2-4-14 at 12:00 p.m., indicated the following: the receiving roommate and or legal representative will be notified of the new roommate prior to the move. This notification will be documented in the medical record. Social Services will follow up with both residents who moved as well as the receiving roommate within 72 hours of the move. The documentation will be placed as to the residents' adjustment to the move/new roommate.</p> <p>3.1-3(v)(2)</p>		<p>times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date will the changes occur? 2/24/2014</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to provide a physician's ordered supplement for 1 of 27 residents reviewed for physician's orders. (Resident #84)</p> <p>Findings include:</p> <p>Resident #84's record was reviewed on 2/4/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia and osteoporosis.</p> <p>Resident #84's significant change Minimum Data Set (MDS) assessment dated 10/29/13, indicated her cognitive skills for daily decision making were severely impaired. She required extensive assistance of 1 person to eat.</p> <p>A physician's order initiated 1/2/14, indicated Resident #84 would continue to receive 120 milliliters (ml) of TWO CAL HN (nutritional supplement) 2 times a day. The amount consumed would be documented.</p>	F000282	F282 Services By Qualified Persons Per Care Plan; It is the practice of Rosebud Village to ensure that physician's ordered supplements are administered per physician's order. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #84's MAR has been updated to reflect physician's order and is being administered. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected. DNS/Designee conducted a chart audit of all resident's with supplements to ensure that all are being administered per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided nurses in-service on following physician's orders. DNS/Designee will review all new supplement orders to ensure accurate transcription to the MAR. How will the corrective actions be monitored to ensure they do not occur again? A	02/24/2014			

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	<p>A physicians order for Resident #84 dated 1/29/14, indicated her TWO CAL HN was changed from 120 ml - 2 times a day, to 60 ml - 4 times a day with her medication pass. The amount consumed would be documented.</p> <p>The 120 ml's of TWO CAL HN was documented as given to Resident #84 - 2 times a day from 1/1/14 through 1/31/14.</p> <p>Resident #84's February 2014 physician's recapitulation orders did not indicate an order for TWO CAL HN.</p> <p>No documentation was available indicating Resident #84 received the TWO CAL HN at all from 2/1/14 through 2/4/14.</p> <p>On 2/4/14 at 3:35 P.M., RN#2 indicated the order written on 1/29/14, for Resident #84 to receive the TWO CAL HN 4 times a day instead of 2 times a day did not get transcribed onto Resident #84's January 2014 orders. She indicated staff had continued to sign off the TWO CAL HN was given 2 times a day for the month of January 2014. RN#4 indicated there was no order for TWO CAL HN to be given to</p>		<p>Supplement Physician's Order CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date will the changes occur? 2/24/2014</p>				

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F000309 SS=D	<p>Resident #84 on the February 2014 physician's recapitulation orders. She indicated there was no documentation Resident #84 received her TWO CAL HN in February 2014.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and record review, the facility failed to identify and investigate an area of scabbing on a resident's temple for 1 of 5 residents reviewed for non pressure skin conditions. (Resident #124)</p> <p>Findings include:</p> <p>Resident #124's record was reviewed on 2/3/14 at 3:05 P.M. Diagnoses included, but were not limited to, post cerebral vascular accident, atrial fibrillation, chronic</p>			F000309	<p>F309 Provide Care Services for Highest Well Being; It is the practice of Rosebud Village to ensure that the facility provides care services for the highest well being of the residents. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #124 had scab prior to admission and POA/Healthcare Rep confirmed no further treatment needed.</p> <p style="text-align: right;">How</p> <p>other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>		02/24/2014

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	<p>back pain, hypertension, and anxiety.</p> <p>Resident #124's quarterly Minimum Data Set (MDS) assessment dated 1/4/14, indicated she required extensive assistance of 2 persons for bed mobility, extensive assistance of 1 person for transfer and toileting. She had functional limitation in her range of motion on both sides of her upper and lower extremities. She had a history of falls at the facility with no injuries.</p> <p>A review of Resident #124's care plans indicated she was at risk for falls, at risk for skin breakdown, and received Hospice services.</p> <p>On 1/27/14 at 11:57 A.M., Resident #124 was observed in her bedroom with 2 small scabbed areas on her left temple. The scabbed areas were approximately 1/8 inch and 1/4 inch long. Resident #124 indicated she did not know how she got the areas to her left temple.</p> <p>On 1/30/14 at 3:31 P.M., Resident #124 was observed seated in her recliner with her feet elevated. Resident #124 continued to have the scabbed areas on her left temple.</p>		<p>action will be taken? All residents had the potential to be affected. DNS/Designee conducted a chart audit of all resident's skin to ensure that skin areas are identified and documented in the resident medical record. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided nurses in-service on Skin Management Program Policy and Procedure. DNS/Designee will complete an additional skin assessment on new admissions to ensure initial admission skin assessments are accurate and areas are identified and documented in the resident medical record. How will the corrective actions be monitored to ensure they do not occur again? A Wound/Skin Management CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date will the changes occur? 2/24/2014</p>		

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	<p>On 1/31/14 at 10:59 A.M., Resident #124 was observed seated in her recliner with her feet elevated. Resident #124 continued to have the scabbed areas on her left temple.</p> <p>On 1/31/14 at 11:02 A.M., RN #3 indicated she did not know how Resident #124 received the scabbed areas to her left temple.</p> <p>On 2/3/14 at 12:48 P.M., Resident #124 was observed seated upright in her bed. Social Service staff from a local Hospice company was in visiting her. Resident #124 continued to have the scabbed areas on her left temple.</p> <p>On 2/4/14 at 12:38 P.M., the Director of Nursing (DoN) indicated she was unable to locate any documentation the scabbed areas on Resident #124's left temple had been recognized and assessed by the facility prior to being informed.</p> <p>The most recent Skin Management Program policy and procedure provided by the Administrator on 2/4/14 at 5:03 P.M., indicated the following: " ...3.) Weekly skin assessments will be completed on all residents as follows: &gt;Weekly skin assessments will be completed</p>			

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	<p>on all residents with or without alterations in skin integrity. &gt;Alterations in skin integrity will be reported to the physician and family member (s). &gt;Physicians orders will be obtained for all alterations in skin integrity identified. &gt;All alterations in skin integrity will be documented in EMR. ...&gt;The care plan will be initiated/revised addressing any new areas. &gt;Direct care givers will be notified of skin alterations and specific care needs. 4.) Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include bruises, open areas, redness, skin tears, blisters, and rashes. 5.) The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported, following the same protocol listed above...."</p> <p>3.1-37(a)</p>			

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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 provide a physician's ordered supplement to maintain acceptable parameters of the resident's nutritional status for 1 of 3 residents reviewed for nutrition of 6 who met criteria for nutrition. (Resident #84)</p> <p>Findings include:</p> <p>Resident #84's record was reviewed on 2/4/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia and osteoporosis.</p> <p>Resident #84's significant change Minimum Data Set (MDS) assessment dated 10/29/13, indicated her cognitive skills for daily decision making were severely impaired. She required extensive assistance of 1 person to eat.</p>	F000325	F325 Maintain Nutrition Status Unless Unavoidable; It is the practice of Rosebud Village to ensure that the facility maintains the nutritional status of the residents unless unavoidable. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #84's orders have been updated to reflect physician's order and are being administered per physician's orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected. DNS/Designee conducted a chart audit of all resident's with supplements to ensure that all are being administered per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided nurses in-service on	02/24/2014

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	<p>A Review of Resident #84's weight indicated she weighed 133.8 pounds on 9/10/13, and 113 pounds on 12/3/13.</p> <p>A physician's order initiated 1/2/14, indicated Resident #84 would continue to receive 120 milliliters (ml) of TWO CAL HN (nutritional supplement) 2 times a day. The amount consumed would be documented.</p> <p>Resident #84's nutrition care plan interventions indicated she would receive TWO CAL supplement 2 times a day.</p> <p>A Dietary Manager's progress note for Resident #84 dated 1/21/14 at 9:50 A.M., indicated she had experienced a 10.8% weight loss in a little over 90 days. No current lab values were available.</p> <p>A Registered Dietician's progress note for Resident #84 dated 1/28/14 at 1:48 P.M., indicated she had shown weight loss in 180 days. Her nutrition was supplemented with 120 ml of TWO CAL 2 times a day, which provided 475 kilocalorie's and 20 grams of protein daily to prevent further weight loss. The Registered Dietician suggested offering the</p>		<p>following physician's orders. DNS/Designee will review all new supplement orders to ensure accurate transcription to the MAR. DNS/Designee will monitor residents' intake by reviewing documentation to ensure residents are offered supplements per physician's order. How will the corrective actions be monitored to ensure they do not occur again? A Supplement Physician's Order CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date will the changes occur? 2/24/2014</p>				

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	<p>supplement in increments of 60 ml for better acceptance.</p> <p>A physicians order for Resident #84 dated 1/29/14, indicated her TWO CAL HN was changed from 120 ml - 2 times a day, to 60 ml - 4 times a day with her medication pass. The amount consumed would be documented.</p> <p>The 120 ml's of TWO CAL HN was documented as given to Resident #84 - 2 times a day from 1/1/14 through 1/31/14.</p> <p>Resident #84's February 2014 physician's recapitulation orders did not indicate an order for TWO CAL HN.</p> <p>No documentation was available indicating Resident #84 received the TWO CAL HN at all from 2/1/14 through 2/4/14.</p> <p>On 2/4/14 at 3:35 P.M., RN#2 indicated the order written on 1/29/14, for Resident #84 to receive the TWO CAL HN 4 times a day instead of 2 times a day did not get transcribed onto Resident #84's January 2014 orders. She indicated staff had continued to sign off the TWO CAL HN was given 2 times a</p>				

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NAME OF PROVIDER OR SUPPLIER  ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>day for the month of January 2014. RN#4 indicated there was no order for TWO CAL HN to be given to Resident #84 on the February 2014 physician's recapitulation orders. She indicated there was no documentation Resident #84 received her TWO CAL HN in February 2014.</p> <p>3.1-46(a)(1)</p>			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to have the correct nurse staffing information that is accessible to the public posted for 2 of 8 survey days. This deficient practice had the</p>	F000356	F356 Posted Nurse Staffing Information; It is the practice of Rosebud Village to ensure that the nurse staffing data is posted. What corrective action will take place for those residents found to be affected by the deficient	02/24/2014			

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	<p>potential to affect 88 of 88 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 1/26/14 at 3:30 P.M., the nurse staffing information was posted on a desk near the facility's entrance. The nurse staffing information posted was dated 1/24/14.</p> <p>On 1/26/14 at 3:45 P.M., LPN #1 indicated the nurse staffing information posted was dated 1/24//14. She indicated the Assistant Director of Nursing usually came in the facility around 6:00 A.M., and posted the nurse staffing information before day shift started.</p> <p>On 1/30/14 at 8:45 A.M., the nurse staffing information was posted on a desk near the facility's entrance. The nurse staffing information posted was dated 1/29/14.</p> <p>During an interview with the Staffing Coordinator, she indicated she was responsible to post the nurse staffing information. She indicated she had been working the floor as a CNA that morning and had not yet posted the nurse staffing information. She indicated she was unsure of who was responsible to</p>		<p>practice? All residents had the potential to be affected, and the nurse staffing data is posted daily. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected, and the nurse staffing data is posted daily by the scheduler Monday through Friday and the weekend manager on Saturday and Sunday. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided education to scheduler, weekend managers and nurses in-service on posting nurse staffing data. The nurse staffing data is posted daily by the scheduler Monday through Friday and the weekend manager on Saturday and Sunday.</p> <p>DNS/Designee will review to ensure nurse staffing data is posted daily. How will the corrective actions be monitored to ensure they do not occur again? A Nurse Staffing Data CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By</p>				

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F009999	<p>complete and post the nurse staffing information when she was not scheduled to work.</p> <p>3.1-13(a)</p> <p>Based on observation, interview and record review the facility failed to notify the Indiana State Department of Health of a busted water pipe in resident room #27, resulting in two residents being required to move from their room and off their unit for 1 of 5 incident reports reviewed for 2 residents that met the criteria for incident reporting (Resident #K and Resident #J).</p> <p>Findings:</p> <p>1.) Interview with the Administrator on 1-29-14 at 10:20 a.m. indicated the facility had a water pipe freeze and bust in resident bedroom #27 on the Alzheimer's unit. The Administrator indicated a portion of the ceiling in room #27 fell down from the busted pipe and the facility water supply was shut off for approximately two hours. The Administrator indicated two</p>	F009999	<p>what date will the changes occur? 2/24/2014</p> <p>F9999 Reporting Reportable Incidents Policy; It is the practice of Rosebud Village to ensure that Reportable Incidents are reported per ISDH Policy. What corrective action will take place for those residents found to be affected by the deficient practice? All residents had the potential to be affected, and the two residents that were moved have been relocated to their room. The facility provided investigation information regarding the broken pipe which resulted in 2 residents moving to a different room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected, and the facility will follow the ISDH Reportable Incidents Policy. Executive Director in-service on following ISDH Reportable Incidents Policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Executive Director in-service on</p>	02/24/2014	

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	<p>residents resided in room #27 and both residents were moved out of the bedroom prior to the ceiling falling down. The Administrator indicated the incident was not reported to the Indiana State Department of Health because there was no structural damage to the facility building and the water supply was not off for four hours. The Administrator indicated the repair of bedroom #27 was still in progress and there was a lock placed on the door so no residents could enter the room. The Administrator indicated Resident #K and Resident #J were the residents residing in room #27, both residents were moved off the Alzheimer unit to the healthcare unit.</p> <p>Review of the record of Resident #K on 1-31-4 at 12:25 p.m. indicated the resident's diagnoses included, but were not limited to, severe late-stage dementia, insomnia, Alzheimer's disease and prostate cancer.</p> <p>The careplan for Resident #K dated 12-21-13 indicated the resident required a secured unit related to Alzheimer's or dementia. The goal was the resident will remain in a safe environment. The interventions included, but were not limited to,</p>		<p>following ISDH Reportable Incidents Policy and will ensure it is followed. Any incidents will be reviewed by DNS and Executive Director to ensure they are reported according to policy. How will the corrective actions be monitored to ensure they do not occur again? An ISDH Reportable Incidents CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date will the changes occur? 2/24/2014</p>		

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	<p>Auguste's cottage (the facility Alzheimer's unit).</p> <p>The Minimum Data Set (MDS) Admission Assessment for Resident #K dated 12-27-13 indicated the following: the resident's BIMS (Brief Interview for Mental Status) was a 3-severe impairment, transfer was extensive assistance of two people and walk in room was extensive assistance of two people.</p> <p>The progress note for Resident #K dated 1-8-14 indicated the resident's family was notified of temporary resident room transfer to room #42 due to a water pipe bursting.</p> <p>During observation on 2-4-14 at 9:50 a.m. Resident #K was lying in bed in room #42 on the healthcare unit of the facility.</p> <p>2.) Review of the record of Resident #J on 2-4-14 at 10:17 a.m. indicated the resident's diagnoses included, but were not limited to, Alzheimer dementia with behaviors, insomnia, anxiety and chronic pain.</p> <p>The careplan for Resident #J dated 9-25-13 indicated the resident required a secured unit related to Alzheimer's or dementia. The goal</p>				

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	<p>was the resident will remain in a safe environment. The interventions included, but were not limited to, Auguste's cottage (the facility Alzheimer's unit).</p> <p>The MDS Admission Assessment for Resident #J dated 9-26-13 indicated the following: BIMS was a 8-moderately impaired, transfer was extensive assistance of two people and walk in room was extensive assistance of two people.</p> <p>The progress note for Resident #j dated 1-8-14 indicated the resident's family was notified of temporary resident room transfer to room #53 due to a water pipe bursting.</p> <p>During observation on 1-29-14 at 1:30 p.m. Resident #J was lying in bed in room #53 on the healthcare unit of the facility.</p> <p>Interview with the Administrator on 1-31-14 at 1:55 p.m. indicated the drywall that fell from the ceiling in room #27 on 1-8-14 was approximately 4 feet by 6 feet in size.</p> <p>Interview and observation with the Maintenance Supervisor of bedroom #27 on the Alzheimer's unit on</p>			

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	<p>2-4-14 at 11:40 a.m., the Maintenance Supervisor indicated on 1-8-14 the hot and cold water pipes froze and split causing a water leak in room #27. The Maintenance Supervisor indicated when he was paged to room #27 on 1-8-14 there were no residents in the bedroom. The Maintenance Supervisor indicated there was water leaking down the wall. The Maintenance Supervisor indicated the main water supply to the facility was shut off on 1-8-14 during repairs from approximately 2:00 p.m. to 4:30 p.m. Maintenance Supervisor indicated as he was fixing the water pipe the drywall on the ceiling fell down. The Maintenance Supervisor indicated he had no documentation of the water pipe break because the supplies to fix the pipes were already at the facility and did not have to be purchased. During observation at this time bedroom #27 on the Alzheimer's unit required a key from the maintenance man to be opened, the room had pieces of drywall on the floor and was in the process of being dry walled on the ceiling.</p> <p>Interview with the Director Of Nursing (DON) on 2-4-14 at 1:15 p.m. indicated on 1-8-14 the staff</p>			

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	<p>noticed water leaking from the wall onto the floor in bedroom #27. The DON indicated Resident #J was in bed and the staff removed him from the room. The DON indicated Resident #K was not in the bedroom at the time the water leak was identified by staff. The DON indicated Resident #K or Resident #J was not in their bedroom when the ceiling fell down.</p> <p>This federal tag relates to Complaint IN00142280.</p> <p>3.1-13(g)(1)</p>			